Austal USA, LLC Group

Health and Welfare Benefit Plan

Amended and Restated July 1, 2020

This plan document, when executed, will constitute a legal instrument with important tax and legal implications. Before you adopt it, you should verify its accuracy, and your legal advisor(s) should confirm and approve it.

TABLE OF CONTENTS

ARTICLE I PLAN ESTABLISHMENT 1
1.1 Effective Date 1
1.2 Purpose 1
1.3 Qualification 1
1.4 Duration 2

ARTICLE II DEFINITIONS 3
2.1 Benefits 3
2.2 Board of Directors 3
2.3 Change in Status 3
2.4 Claim Administrator 4
2.5 Code 4
2.6 COBRA 4
2.7 Company 4
2.8 Covered Employee 4
2.9 Covered Person 4
2.10 Dependent 5
2.11 Dependent Care Spending Account Plan 5
2.12 Effective Date 5
2.13 Employee 5
2.14 Employer 6
2.15 ERISA 6
2.16 FMLA 6
2.17 Full-Time Employee 6
2.18 Health Care Spending Account Plan 6
2.19 HRA Account 6
2.20 HIPAA 6
2.21 Incorporated Document 7
2.22 Plan 7
2.23 Plan Administrator 7
2.24 Plan Year 7
2.25 Salary Deduction Agreement 7
2.26 Salary Deduction Contributions 7
2.27 Salary Reduction Agreement 7
2.28 Salary Reduction Contributions 7
2.29 Spouse 7

ARTICLE III ELIGIBILITY, PARTICIPATION AND COVERAGE 8
3.1 Eligibility 8
3.2 Participation 8
3.3 Coverage 8
3.4 Coverage under the Family and Medical Leave Act and Section 609 of ERISA 11

3.5 Uniformed Services Employment and Reemployment Rights Act 11
3.6 Health Insurance Portability and Accountability Act of 1996 11
3.7 Coordination with State Medicaid Program 12
3.8 Mental Health Parity Act and Mental Health Parity and Addiction Equity Act 12
3.9 Women's Health and Cancer Rights Act 12
3.10 Newborns' and Mothers' Health Protection Act 13
3.11 Genetic Information Nondiscrimination Act of 2008 13
3.12 Children's Health Insurance Program Reauthorization Act of 2009 13
3.13 Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act 13

ARTICLE IV BENEFITS 14
4.1 Benefits 14
4.2 Options 14
4.3 Unreduced Compensation Benefit 14
4.4 Buy-Out Option 15
4.5 Opt-Out Benefit 15
4.6 Elective Benefits 16
4.7 Non-Elective Benefits 19
4.8 Limits for Certain Employees 19
4.9 Notification of Premium Payment Amounts 20
4.10 Application of Other Plans 20

ARTICLE V ELECTIONS 21
5.1 Enrollment for Non-Elective Benefits 21
5.2 Enrollment for Elective Benefits 21
5.3 Salary Reduction/Deduction Agreements 21
5.4 Forms and Agreements 21
5.5 Default Benefits 22
5.6 Deadlines 22
5.7 Validity of Election Forms 23
5.8 Changing Elections 23

ARTICLE VI COORDINATION OF BENEFITS 29
6.1 Applicability 29
6.2 COB Definitions 29
6.3 Order of Benefit Determination Rules 30
6.4 Effect on the Benefits of this Plan 32
6.5 Limitation of Benefits 33
6.6 Right to Receive and Release Necessary COB Information 33
6.7 Facility of Payment 33
6.8 Right of Recovery 33
6.9 Governing Provisions 34

ARTICLE VII COBRA CONTINUATION COVERAGE 35
7.1 Eligibility for Continuation Coverage 35
7.2 Definitions 35
7.3 Loss of Eligibility for Continuation Coverage 36
7.4 Termination of COBRA Continuation Coverage 36
7.5 Notice Requirements 37
7.6 Coverage Available for Continuation 38
7.7 Election Rules 39
7.8 Required Premium 40
7.9 Governing Provisions 40

ARTICLE VIII CONTRIBUTIONS, FUNDING AND PLAN ASSETS 41
8.1 Contributions 41
8.2 Funding 42
8.3 Plan Assets 42
8.4 Treatment of Certain Policy Payments 42

ARTICLE IX CLAIM AND PAYMENT PROCEDURES 43
9.1 General Claims Procedures 43
9.2 Claim Administrator 43
9.3 Claims Administration 43
9.4 Claimants 44
9.5 Claim Forms 44
9.6 Deadline for Filing a Claim 44
9.7 Proof of Claim 44
9.8 Decision on the Claim 44
9.9 Right to Appeal 48
9.10 Legal Remedy 53
9.11 Third Party Liability Claims 53
9.12 Payment Procedures 55
9.13 External Review 57

ARTICLE X ADMINISTRATION 57
10.1 Plan Administrator 57
10.2 Plan Administrator's Duties 57
10.3 Plan Administrator's Powers 58
10.4 Finality of Decisions 59
10.5 Compensation and Bonding of Plan Administrator 59
10.6 Liability Insurance 59
10.7 Reserved Powers 59

ARTICLE XI AMENDMENT, TERMINATION OR MERGER OF PLAN 60
11.1 Right to Amend the Plan 60
11.2 Right to Terminate or Merge the Plan 60
11.3 Effect of Amendment, Termination or Merger 60

ARTICLE XII MISCELLANEOUS 61
12.1 No Employment Rights 61
12.2 Exclusive Rights 61
12.3 No Property Rights 61
12.4 No Assignment of Benefits 61
12.5 Right to Offset Future Payments 61
12.6 Right to Recover Payments 62
12.7 Misrepresentation or Fraud 62
12.8 Legal Action 62
12.9 Governing Law 62
12.10 Governing Instrument 63
12.11 Savings Clause 63
12.12 Captions and Headings 63
12.13 Notices 63
12.14 Waiver 63
12.15 Parties' Reliance 63
12.16 Disclaimer 64
12.17 Expenses 64
12.18 Indemnification 64
12.19 Employees' Tax Obligations 64

ARTICLE XIII HIPAA PRIVACY AND SECURITY 66
13.1 Scope 66
13.2 Definitions 66
13.3 Uses and Disclosures of PHI 67
13.4 Privacy Agreements of the Employer 67
13.5 Security Agreements of the Employer 69

APPENDIX A AUSTAL USA, LLC DEPENDENT CARE SPENDING ACCOUNT PLAN 1

ARTICLE I PLAN ESTABLISHMENT 1
1.1 Effective Date 1
1.2 Purpose 1
1.3 Qualification 1
1.4 Incorporation By Reference 1
1.5 Duration 1

ARTICLE II DEFINITIONS 2
2.1 Covered Employee 2
2.2 Dependent Care Expenses 2
2.3 Dependent Care Spending Account Plan 2
2.4 Effective Date 2
2.5 Exclusions 2
2.6 Maximum Annual Benefit 2
2.7 Plan 2
2.8 Plan Year 2

2.9 Qualifying Individual 3

ARTICLE III PARTICIPATION 4
3.1 Participation 4
3.2 Termination of Participation 4

ARTICLE IV DEPENDENT CARE REIMBURSEMENT BENEFIT 5
4.1 Right to Benefit 5
4.2 Maintenance of Accounts 5
4.3 Amount Payable 5
4.4 Dependent Care Expenses 5
4.5 Limits 6

ARTICLE V EXCLUSIONS 9
5.1 General Rules 9
5.2 Specific Exclusions 9
5.3 Conditional Exclusions 10

ARTICLE VI PROCEDURES 11
6.1 Enrollment and Election Procedures 11
6.2 Claim Procedures 11
6.3 Claim Administrator 11
6.4 Claims Administration 11
6.5 Proof of Claim 11

APPENDIX B AUSTAL USA, LLC HEALTH CARE SPENDING ACCOUNT PLAN 1

ARTICLE I PLAN ESTABLISHMENT 1
1.1 Effective Date 1
1.2 Purpose 1
1.3 Qualification 1
1.4 Incorporation By Reference 1
1.5 Duration 1

ARTICLE II DEFINITIONS 2
2.1 Covered Employee 2
2.2 Dependent 2
2.3 Effective Date 2
2.4 Exclusions 2
2.5 Health Care Spending Account 2
2.6 Maximum Annual Benefit 2
2.7 Plan 3
2.8 Plan Year 3
2.9 Qualifying Medical Expenses 3

ARTICLE III PARTICIPATION 4
3.1 Participation 4

3.2 Termination of Participation ... 4

ARTICLE IV MEDICAL EXPENSE BENEFIT ... 5
4.1 Right to Benefit ... 5
4.2 Maintenance of Accounts ... 5
4.3 Amount Payable ... 5
4.4 Qualifying Medical Expenses ... 5
4.5 Limits ... 6

ARTICLE V EXCLUSIONS ... 8
5.1 General Rules ... 8
5.2 Specific Exclusions ... 8

ARTICLE VI PROCEDURES ... 10
6.1 Enrollment and Election Procedures ... 10
6.2 Claim Procedures ... 10
6.3 Claim Administrator ... 10
6.4 Claims Administration ... 10
6.5 Proof of Claim ... 10

APPENDIX C HEALTH REIMBURSEMENT ARRANGEMEN ... 12
1.1 Participation ... 13
1.2 General Rules ... 13
1.3 Coverage Period ... 13
Coverage Period means the Plan Year. ... 13
1.4 Dependent ... 13
1.5 Amounts Credited to HRA ... 13
1.6 Healthcare Related Expenses ... 14
1.7 Expenses Covered Under Any Other Health Plan Coverage ... 14
1.8 Amounts credited as of the End of a Coverage Period ... 14
1.9 Requests for Reimbursement ... 14
1.10 Minimum Reimbursement Amounts ... 15
1.11 Requests Exceeding Accrued HRA Account Balance ... 15
1.12 Termination of Participation ... 15

APPENDIX D SPECIFIC PROVISIONS APPLICABLE TO DIFFERENT CLASSES OF EMPLOYEES ... 1

APPENDIX E APPLICABLE INCORPORATED DOCUMENTS ... 1

APPENDIX F EMPLOYEES OF THE EMPLOYER APPROVED TO HAVE ACCESS TO PROTECTED HEALTH INFORMATION ... 1

ARTICLE I

PLAN ESTABLISHMENT

1.1 Effective Date

The Austal USA, LLC Group Health and Welfare Benefit Plan ("the Plan") originally effective July 1, 2011, is hereby amended and restated effective July 1, 2020

1.2 Purpose

The Plan has been created to provide specified health and welfare benefits for the exclusive benefit of Covered Persons, as defined in Section 2.9.

The Plan is also intended to give Covered Employees, as defined in Section 2.8, means to exchange all or part of their compensation for other Plan benefits they select.

1.3 Qualification

To the extent this Plan provides specified health and welfare benefits, it is intended to satisfy the written plan document requirements of section 402 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The portion of the Plan that constitutes the health and welfare plan under ERISA are: the Medical Benefits, the Dental Benefits, the Employee Assistance Benefits, the Basic Life, and Supplemental Life Benefits, Dependent Life Benefits, Basic AD&D and Supplemental AD&D Benefits, Short-Term Disability Benefits, Long-Term Disability Benefits, Spousal Incentive HRA, International Medical Benefits and the Health Care Flexible Spending Account, along with those other provisions of this document that are necessary or appropriate to the implementation and administration of listed benefits. The inclusion of the Dependent Care Spending Account in this Plan document, and the inclusion of any other benefit that is not otherwise subject to ERISA shall not subject such benefit to ERISA.

To the extent this Plan provides permitted taxable benefits and qualified benefits under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code"), it is intended also to qualify as a cafeteria plan under section 125 of the Code. This document is intended to satisfy the written plan document requirements of Department of Treasury Proposed Regulations section 1.125-1. The portions of the plan that constitute the cafeteria plan and the term "Cafeteria Plan" shall mean those provisions of this document that are necessary or appropriate to the implementation and administration of Employee elections among the following listed benefits: the unreduced compensation benefit, the Buy-Out Option, Opt-Out Benefit, the Medical Premium Payment Benefit, the Dental Premium Payment Benefit, the Health Care Spending Account Premium Payment Benefit and the Dependent Care Spending Account Premium Payment Benefit. The cafeteria plan is for Covered Employees only.

The Dependent Care Spending Account Plan, as defined in Section 2.11 and set forth in Appendix A, is part of this Plan and is intended to qualify as a dependent care assistance

program under section 129 of the Code. Appendix A is intended to satisfy the written plan document requirement of Code section 129(d)(1).

The Health Care Spending Account Plan, as defined in Section 2.18 and set forth in Appendix B, is part of this Plan and is intended to be an employee welfare benefit plan under section 3(3) of ERISA. Appendix B is intended to satisfy the written plan document requirement of ERISA section 402. The Health Care Spending Account Plan is intended to qualify as a health plan under section 105(e) of the Code. Appendix B is also intended to satisfy the written plan document requirement of Department of Treasury regulation section 1.105-11(b)(1)(i).

1.4 Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Employer, as defined in Section 2.14, in its sole discretion and in accordance with the provisions of Article XI may amend or terminate the Plan or any provision of the Plan at any time.

ARTICLE II

DEFINITIONS

The following words and phrases, when capitalized, shall have the following meanings.

2.1 Benefits

Benefits mean the health and welfare coverages provided under the Plan and as more particularly described in Article IV. Certain benefits are provided to any Employee who meets the eligibility requirements of Section 3.1, while certain other benefits are provided only upon selection by an Employee who meets the eligibility requirements of Section 3.1.

2.2 Board of Directors

Board of Directors means the persons and their successors, appointed or elected to manage and direct the affairs of the Company.

2.3 Change in Status

Change in Status means:

A. a "special enrollment" event under HIPAA,

B. the Covered Employee's marriage, divorce, legal separation, or annulment,

C. the birth, adoption, placement for adoption, or change in dependency or custody of a Covered Employee's child,

D. the death of the Employee's Spouse or Dependent child,

E. a change in employment status by the Covered Employee, Spouse or Dependent, including commencement or termination of employment, a change in work shift, a change in worksite, a reduction or increase in hours of employment including changing from part-time to full-time employment status, a strike or lockout,

F. commencement or return from an unpaid leave of absence by the Employee, Spouse or Dependent,

G. a change in worksite or personal residence resulting in eligibility or loss of eligibility of coverage for the Covered Employee, Spouse or Dependent under any health maintenance organization offered through the Plan,

H. a change in legal custody (including the issuance of a Qualified Medical Child Support Order) that affects the child's eligibility for coverage under this Plan or the plan of the child's other parent,

I. entitlement or loss of entitlement to Medicare or Medicaid by the Employee, Spouse or Dependent,

J. attainment by Dependent child of limiting age for a benefit provided under this Plan,

K. loss of "qualifying individual" status, as defined in Section 2.9 of the Dependent Care Spending Account Plan,

L. any other event the Plan Administrator determines permits revocation of an election without violating the Code.

2.4 Claim Administrator

Claim Administrator means the person(s) or entity (or entities) authorized and responsible for receiving and reviewing claims for benefits under the Plan; determining what amount, if any, is due and payable; making appropriate disbursements to persons entitled to benefits under the Plan; and reviewing and determining denied claims and appeals.

2.5 Code

Code means Internal Revenue Code of 1986, as amended, and regulations issued thereunder or pursuant thereto.

2.6 COBRA

COBRA means the Consolidated Omnibus Reconciliation Act of 1985 (Public Law 99-272, Title X), as amended, and the regulations issued thereunder or pursuant thereto.

2.7 Company

Company means Austal USA, LLC a limited liability company, and any successor, by merger or otherwise.

2.8 Covered Employee

Covered Employee means an Employee who satisfies the eligibility, participation, and coverage requirements of Article III.

2.9 Covered Person

Covered Person means a Covered Employee or Dependent who has satisfied the eligibility and enrollment provisions of Article III or, if applicable, the provisions of Article VII.

A Covered Person may have Plan coverage with respect to certain benefits, but not all benefits, as hereinafter described in the Plan.

2.10 Dependent

Dependent means a Spouse, or dependent child of an Employee who is a Covered Person as determined under the applicable Incorporated Document.

Regardless of whether a Dependent is eligible for a Benefit under this Plan, a Covered Employee may only make Salary Reduction Contributions for Benefits for an Employee's dependent who is a Covered Person as follows:

A. Spouse,

B. dependent as defined in Code section 152 (without regard to (b)(1), (b)(2), and (d)(1)(B)) or,

C. the Covered Employee's child as defined in Code section 152(f)(1)) who has not attained age 26 .

A Dependent may be eligible for coverage with respect to certain benefits, but not all benefits, as hereinafter described in the Plan.

2.11 Dependent Care Spending Account Plan

Dependent Care Spending Account Plan means the plan set forth in Appendix A.

2.12 Effective Date

Effective Date means the date the Plan becomes operative; the Effective Date is July 1, 2011. The Plan is amended and restated effective July 1, 2020.

2.13 Employee

For purposes of this Plan only, the term Employee means a person currently performing services under his or her Employer's control.

The term *Employee* does not mean:

A. a self-employed individual, as defined in Code section 401(c)(1)(A),

B. a member of the Board of Directors who is not otherwise an employee,

C. a person whom the Plan Administrator determines has been engaged by the Employer as an independent contractor, and

D. a person whom the Plan Administrator determines has been engaged by the Employer as a consultant or advisor on a retainer or fee basis.

A person the Plan Administrator determines is not an "Employee" as defined above shall not be eligible to participate in the Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters.

2.14 Employer

Employer means the Company and any subsidiary or affiliated organization and any successor(s) of any of them which, with the approval of the Company, and subject to such conditions as the Company may impose, adopts the Plan.

For purposes of satisfying the nondiscrimination requirements of Code section 125(b), section 105(h) and 129(d), the term "Employer" shall include any other corporation or other business entity which must be aggregated with the Employer under sections 414(b), (c), (m) or (o) of the Code, but only for such period of time when the Employer or such other corporation or other business entity must be aggregated as aforesaid.

2.15 ERISA

ERISA means the Employee Retirement Income Security Act of 1974, as amended, and the regulations issued thereunder or pursuant thereto.

2.16 FMLA

FMLA means the Family and Medical Leave Act of 1993, as amended, and the regulations issued thereunder or pursuant thereto.

2.17 Full-Time Employee

Full Time Employee means an Employee who is regularly scheduled to work at least 30 hours per week.

2.18 Health Care Spending Account Plan

Health Care Spending Account Plan means the plan set forth in Appendix B.

2.19 HRA Account

HRA Account shall mean the balance posted to the nominal recordkeeping account of the Health Reimbursement Arrangement on behalf of each Participant less any payment therefrom, in accordance with Appendix C and the Applicable Document set forth in Appendix E.

2.20 HIPAA

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued thereunder or pursuant thereto.

2.21 Incorporated Document

Incorporated Document means an insurance policy, administrative services agreement, plan, trust, certificate of coverage, evidence of coverage, summary plan description or other document incorporated by reference, together with any exhibits, supplements, addendums or amendments thereto. The Incorporated Documents are listed in Appendix E.

2.22 Plan

Plan means the Austal USA, LLC Group Health and Welfare Benefit Plan, as herein set forth and as amended from time to time.

2.23 Plan Administrator

Plan Administrator means the person(s) authorized and responsible for managing and directing the operation and administration of the Plan.

2.24 Plan Year

Plan Year means the 12-month period beginning July 1 and ending June 30.

2.25 Salary Deduction Agreement

Salary Deduction Agreement means the authorization to the Employer by the Employee to reduce such Employee's pay by an amount on an after-tax basis for selected Plan benefits.

2.26 Salary Deduction Contributions

Salary Deduction Contributions means the contributions taken from the Covered Employee's salary on an after-tax basis, pursuant to a Salary Deduction Agreement.

2.27 Salary Reduction Agreement

Salary Reduction Agreement means the authorization to the Employer by the Employee to reduce such Employee's pay by an amount on a before-tax basis for selected Plan benefits.

2.28 Salary Reduction Contributions

Salary Reduction Contributions means the contributions taken from the Covered Employee's salary on a before-tax basis, pursuant to a Salary Reduction Agreement.

2.29 Spouse

Spouse means, for purposes of this Plan only, the Covered Employee's opposite sex spouse as determined under applicable state law. Effective May 1, 2015, Spouse shall mean the Covered Employee's opposite sex and same sex spouse as determined under applicable state law.

ARTICLE III

ELIGIBILITY, PARTICIPATION AND COVERAGE

3.1 Eligibility

An Employee shall become eligible for Plan participation on the date determined in Appendix D.

The following Employees are not eligible to participate in the Plan:

A. Employees regularly scheduled to work fewer than 30 hours per week;

B. Employees who are hired on a *temporary* basis, with the classification *temporary* meaning any Employee who is hired as part of a work/study cooperative program or intern on a short-term defined basis, as designated by the Plan Administrator;

C. Leased employees, as defined in Code section 414(n);

D. Employees in an employee unit covered by a collective bargaining agreement between Employee representatives and one or more Employers if this Plan's benefits were the subject of good faith bargaining between the Employee representatives and the Employer, unless such agreement provides for coverage for such bargaining employees in the Plan; and

E. Nonresident aliens who receive no earned income (within the meaning of the Code section 911(d)(2)) from an Employer that constitutes income from sources within the United States, as defined in Code section 861(a)(3).

3.2 Participation

Employees become Plan participants with respect to non-elective Benefits on the date they satisfy the eligibility requirements of Section 3.1. Employees become Plan participants with respect to elective Benefits on the date they also satisfy the enrollment and election requirements of Section 5.4.

3.3 Coverage

A. Date Coverage Begins

The provisions and requirements describing when and how Employees and Dependents become Covered Persons, the conditions and limitations to coverage, and the circumstances wherein coverage terminates shall be set forth in Appendix D and in the Incorporated Documents by reference under Section 4.1. In addition, coverage is governed by the rules stated below and in Section 5.8.

B. Coverage During Leave of Absence

1. Paid Leave

During a paid leave of absence, a Covered Employee continues to participate in the premium payment benefits he or she elected.

2. Unpaid Leave

For Plan benefits not requiring Employee contributions, a Covered Employee remains covered for such benefits during an unpaid leave of absence.

Except as otherwise provided below, for Plan benefits requiring an Employee contribution, coverage for a Covered Employee on an approved unpaid leave of absence shall continue for no more than 30 days following the date of the commencement of the leave. To the extent the Covered Employee may continue coverage during an unpaid leave, the Covered Employee is required to pay for coverage on an after-tax basis. The terms of the plan to which the participant's selected premium payment benefits were paid control whether and to what extent coverage and benefits under that plan continue.

If the unpaid leave of absence is taken pursuant to FMLA, Covered Employees may elect to continue participation in premium payment benefits described in Sections 4.6 (A), (B), and (C) by (i) pre-paying on a before-tax basis the premiums for coverage during the leave, or (ii) paying on a before-tax basis upon return from the leave the premium payment benefits for coverage during the leave, and adjusting the Salary Reduction Contribution accordingly for the balance of the Plan Year. Benefits described in Section 4.6 (D) are suspended.

With respect to premium payment benefits described in Section 4.6(C), if the Covered Employee elects to revoke such coverage during the unpaid leave, no expenses incurred during the leave shall be reimbursed. Upon return from leave, the Employee can either: i) elect to be reinstated in the prior election amount, reduced by the dollar amount of the annual election not contributed during the unpaid leave, or ii) elect to be reinstated to the full annual election amount, with the Salary Reduction Contribution adjusted accordingly for the balance of the Plan Year.

C. Date Coverage Ceases

Coverage for a specific benefit offered under the Plan ceases on the earliest of:

1. the Covered Employee’s date of employment termination

2. except where participation continues during an unpaid leave of absence, the last day of the last pay period for which a Covered Employee makes a Salary Reduction Contribution or Salary Deduction Contribution with respect to an elective Benefit,

3. the effective date of a Plan amendment that terminates coverage for the Covered Employee's job category,

4. the date the Plan terminates.

A Covered Employee’s Dependent shall cease to be a Covered Person if the Employee ceases to be a Covered Person, except as otherwise provided in Article VII.

D. Effect of Terminated Coverage

Termination of coverage automatically cancels a Covered Employee's Salary Reduction Agreement and Salary Deduction Agreement on the date coverage terminates. Coverage and benefits may continue in effect to the extent provided in an applicable Incorporated Document.

E. Reinstatement of Coverage

1. If Previously Suspended

A Covered Employee who returns to an Employer's service during the same Plan Year that he or she took an unpaid leave of absence will have reinstated automatically the Benefits in effect when Plan coverage was suspended provided such benefits continue to be provided by the Company. If an unpaid leave of absence was taken in accordance with FMLA, such Covered Employee may reinstate his or her election and Salary Reduction Agreement for the remainder of the Plan Year if participation has not continued pursuant to Section 3.3(B). In all other cases, the Covered Employee may only make any new benefit elections for the remainder of the Plan Year, as described in Section 5.8.

2. If Previously Terminated

A Covered Employee who returns to an Employer's service shall be eligible to participate in the Plan and make new benefit elections, provided such Employee satisfies the eligibility requirements of Section 3.1. Notwithstanding the foregoing, if a former Covered Employee returns to service during the same Plan Year and within 30 days of the date prior participation ended, his or her elections for Benefits described in Section 4.4, 4.5, and 4.6 (A), (B), C), and (D) shall be reinstated for the remainder of the Plan Year, except as described in Section 5.8. The above rule shall not apply and the rehired Employee shall be eligible to make new

elections for Benefits described in Section 4.4, 4.5, and 4.6 (A), (B), (C), or (D) for the balance of the Plan Year, if it is determined to the satisfaction of the Plan Administrator that the prior termination of employment and reinstatement was bona fide and not an attempt to avoid the irrevocable rule described in Section 5.8(A).

3.4 Coverage under the Family and Medical Leave Act and Section 609 of ERISA

A. Family and Medical Leave Act of 1993

If not otherwise provided for herein, the Plan shall provide coverage for a Covered Employee solely to the extent necessary to comply with FMLA, and the Plan shall be interpreted and administered as necessary to comply with FMLA and the rulings and regulations issued thereunder.

B. Section 609 of ERISA

If not otherwise provided for herein, the Plan shall provide coverage to a child solely to the extent required by a qualified medical child support order defined under section 609(a) of ERISA or to an adoptive child or child placed for adoption solely to the extent required by section 609(c) of ERISA. Further, the Plan shall be interpreted and administered as necessary to comply with section 609 of ERISA and the rulings and regulations issued thereunder.

C. Coverage Contingent Upon Contribution

Any coverage provided as a result of this Section 3.4 shall be conditioned upon payment of applicable contributions by the Employee.

3.5 Uniformed Services Employment and Reemployment Rights Act

Solely to the extent required by the Uniformed Services Employment and Reemployment Rights Act (hereafter the "Uniformed Services Act"), a Covered Person who is an Employee who enters military service shall have the right to continue coverage under the Plan for the period prescribed under the Uniformed Services Act. Continuation of coverage shall be conditioned upon payment of the required premiums, if any.

This Section 3.5 shall be interpreted and applied to give an Employee only those rights as are prescribed under the Uniformed Services Act and rulings and regulations issued thereunder.

3.6 Health Insurance Portability and Accountability Act of 1996

A. HIPAA Title I

Solely to the extent required by the Health Insurance Portability and Accountability Act of 1996 (hereinafter "HIPAA"), and Employee shall be a Covered Person under the Plan no later than such time as required under HIPAA, and the Plan shall

be subject to the special enrollment, pre-existing condition limitations and nondiscrimination in health status provisions of HIPAA. This Section 3.6 shall be interpreted and applied to give an Employee only those rights as prescribed under HIPAA and the rulings and regulations issued thereunder.

B. HIPAA Title II

The Plan shall comply with the privacy and security regulations of HIPAA, in accordance with the provisions set forth in Article XIII.

3.7 Coordination with State Medicaid Program

The fact that a Covered Person is eligible for coverage by, or is covered by, a State Medicaid program shall not affect the Covered Person's eligibility to participate in the Plan or to receive benefits. The payment of benefits under the Plan with respect to any Covered Person shall be made in accordance with any assignment of rights made by or on behalf of the Covered Person of a beneficiary of the Covered Person as required by any State Medicaid program, as provided in Section 609(b) of ERISA. To the extent a payment has been made to or with respect to a Covered Person pursuant to a State Medicaid program and the amount so paid is for a medical expense that the Plan has a legal liability to pay, the Plan will pay such expense in accordance with any State law that provides that the State has acquired the right with respect to the Covered Person to receive payment for such expense.

3.8 Mental Health Parity Act and Mental Health Parity and Addiction Equity Act

Solely to the extent required by the Mental Health Parity Act and the Mental Health Parity and Addiction Equity Act of 2008, the Plan shall provide mental health benefits to the same extent as other medical benefits.

This Section 3.8 shall be interpreted and applied to give an Employee only those rights as prescribed under the Mental Health Parity Act and the Mental Health Parity and Addiction Equity Act, and the rulings and regulations issued thereunder.

3.9 Women's Health and Cancer Rights Act

Solely to the extent required under the law of the Women's Health and Cancer Rights Act (hereinafter "WHCRA"), the Plan shall provide certain benefits related to benefits received in connection with a mastectomy.

In the case of a Covered Person who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the coverage shall be provided in a manner determined in consultation with the attending physician and the patient for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Such reconstructive benefits are subject to annual plan deductibles and coinsurance provisions such as other medical and surgical benefits covered under the Plan.

This Section 3.9 shall be interpreted and applied to give an Employee only those rights as prescribed under WHCRA, and the rulings and regulations issued thereunder.

3.10 Newborns' and Mothers' Health Protection Act

Solely to the extent required by the Newborns' and Mothers' Health Protection Act (hereinafter "NMHPA"), the Plan shall provide that coverage for childbirth may not be limited to a hospital stay of less than 48 hours for normal delivery, or less than 96 hours for cesarean section, or require the provider to obtain approval for shorter hospital stays. The requirement shall not apply if the attending provider, in consultation with the mother, decides to discharge the mother or newborn earlier than the time prescribed by the NMHPA.

This Section 3.10 shall be interpreted and applied to give Covered Persons only those rights as prescribed under the NMHPA, and the rulings and regulations issued thereunder.

3.11 Genetic Information Nondiscrimination Act of 2008

The Plan shall comply with the Genetic Information Nondiscrimination Act of 2008 (hereinafter "GINA").

This Section 3.11 shall be interpreted and applied to give Covered Persons only those rights as prescribed under GINA, and the rulings and regulations issued thereunder.

3.12 Children's Health Insurance Program Reauthorization Act of 2009

The Plan shall comply with the Children's Health Insurance Program Reauthorization Act of 2009 (hereinafter "CHIP").

This Section 3.12 shall be interpreted and applied to give Covered Persons only those rights as prescribed under CHIP, and the rulings and regulations issued thereunder.

3.13 Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act

The Plan shall comply with the applicable provisions of the Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act (HCERA).

This Section 3.13 shall be interpreted and applied to give Covered Persons only those rights as prescribed under PPACA as amended by HCERA, and the rulings and regulations issued thereunder.

ARTICLE IV

BENEFITS

4.1 Benefits

The benefits provided under the Plan are described as set forth below and as further described in any applicable Incorporated Document. Any such applicable Incorporated Document is hereby incorporated by reference as if set forth in full herein. Pursuant to Section 8.1(B) any Salary Reduction Agreements and/or Salary Deduction Agreements issued in conjunction with the Plan are incorporated by reference.

4.2 Options

Covered Employees must elect one of the following:

A. to forego all or part of the unreduced compensation benefit described in Section 4.3 and forego the Buy-Out Option described in Section 4.4, and forego the Opt-Out Benefit described in Section 4.5, and make before- or after-tax contributions in exchange for one or a combination of Benefits described in Section 4.6 and receive automatic coverage under Benefits described in Section 4.7;

B. for eligible Employees, to receive the Buy-Out Option described in Section 4.5 and receive no benefits under the Plan, or

C. to forego the Buy-Out Option described in Section 4.4, and to receive the Opt-Out Benefit described in Section 4.5, and the full unreduced compensation benefit described in Section 4.3, and receive automatic coverage under Benefits described in Section 4.7;

Employee contributions for Benefits described in Sections 4.6 (A), (B), (C), and (D) must be made on an entirely before-tax basis through a Salary Reduction Agreement. Employee contributions for Benefits described in Sections 4.6 (E), (F), (G), (H) and (I) may be made only on an after-tax basis through a Salary Deduction Agreement. There are no Employee Contributions for Benefits described in Sections 4.7.

4.3 Unreduced Compensation Benefit

In lieu of all or some of the Benefits described in Section 4.6 that a Covered Employee otherwise could elect, he or she may elect to receive unreduced compensation in an amount equal to the value of the Benefits available for election that are not elected. The unreduced compensation benefit is subject to the Employer's regular payroll practices; applicable local, state, and federal income tax withholding; and other applicable deductions. The unreduced compensation benefit is not additional compensation; it is the amount by which a Covered Employee's compensation is not reduced each pay period by not electing a premium payment benefit. The unreduced compensation benefit shall cease whenever the Covered Employee commences an unpaid leave of absence, terminates

employment, or the Covered Employee's Employer determines, in its sole discretion, that compensation is not payable to such Employee.

4.4 Buy-Out Option

A. A Covered Employee who is a non-exempt Employee may waive coverage under Company-sponsored benefits and in lieu thereof receive an hourly rate increase of $4.00.

For purposes of this Section 4.5, Company-sponsored benefits that can be waived shall be all Benefits described in Section 4.6 and 4.7 plus other benefits not described in this Plan including paid vacation time, personal time, holiday pay, funeral leave, Company paid short-term disability, boot allowance, educational assistance benefits, and prescription safety glass allowance.

None of the above-referenced benefits shall be payable for any Plan Year for which the Employee receives the Buy-Out Option.

The Buy-Out Option is not payable:

1. for any period during which the Plan is required to provide coverage for a child of such Employee pursuant to a qualified medical child support order

2. to any Employee who is covered for medical or dental benefits under the Plan as a dependent.

If an Employee has elected the Buy-Out Option and the Plan receives a qualified medical child support order with respect to a child of the Employee, the Buy-Out Option shall be deemed revoked, the Employee shall be again eligible for the benefits described above that have been waived, and the increased rate of pay shall cease to be payable for any period beginning as of the date the order takes effect.

4.5 Opt-Out Benefit

A. A Covered Employee who has not elected the Buy-Out Option described in Section 4.4 may waive coverage under Section 4.6 (a) and (B) and in lieu thereof receive a monthly benefit of $175 provided such Employee provides satisfactory evidence of coverage under another medical and dental plan.

B. The Opt-Out Benefit is not payable:

1. for any period during which the Plan is required to provide coverage for a child of such Employee pursuant to a qualified medical child support order

2. to any Employee who is covered for medical or dental benefits under the Plan as a dependent

C. The amount of the Opt-Out Benefit shall be paid in such a manner and at such time as may be determined by the Company. The Opt-Out Benefit shall be subject to any applicable withholding in similar taxes.

D. A Covered Employee who elects to waive medical and dental benefits and receive the Opt-Out Benefit may not revoke such election until the next annual enrollment election period, except as allowed pursuant to Section 5.8 (C).

4.6 Elective Benefits

By electing one or more premium payment benefits, an Employee converts a portion of his or her compensation for the Plan Year into contributions for the Benefits selected. Covered Employees may elect one or more of these premium payment benefits:

A. Medical Premium Payment Benefit

Covered Persons shall have the right to the medical benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Incorporated Document. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for medical benefits, he or she may elect any of the medical plan options as the medical premium payment benefit.

B. Dental Premium Payment Benefit

Covered Persons shall have the right to the dental benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Incorporated Document. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for dental benefits, he or she may elect any of the dental plan options as the dental premium payment benefit.

C. Health Care Spending Account Premium Payment Benefit

Employees who are Covered Persons shall have the right to the health care spending account benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions and limitations set forth in such Incorporated Document. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for the health care spending account benefits, he or she may elect any whole dollar annual contribution amount of not more than $2,750, or if less, the maximum amount allowed under Section 125 of the Code, as the health care spending account premium payment benefit.

D. Dependent Care Spending Account Premium Payment Benefit

Employees who are Covered Persons shall have the right to the dependent care spending account benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions and limitations set forth in such Incorporated Document. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for dependent care spending account benefits, he or she may elect any whole dollar annual contribution amount of not more than $5,000 as the dependent care spending account premium payment benefit.

E. Supplemental Short-Term Disability Premium Payment Benefit

Employees who are Covered Persons shall have the right to the supplemental short term disability benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions preceded to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for supplemental short-term disability benefits, he or she may elect any of the supplemental short-term disability coverage options as the supplemental short-term disability premium payment benefit.

F. Voluntary Long-Term Disability Premium Payment Benefit

Covered Persons who are Hourly Non-exempt Employees shall have the right to the voluntary long-term disability benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions preceded to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for voluntary long-term disability benefits, he or she will be automatically enrolled for coverage and may elect to decline any of the voluntary long-term disability coverage options as the voluntary long-term disability premium payment benefit.

G. Supplemental Life Premium Payment Benefit

Employees who are Covered Persons shall have the right to the supplemental life insurance benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Document. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions, the procedure for naming beneficiaries and consequences for failure to name a beneficiary, shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for supplemental life benefits, he or she may elect any of the supplemental life coverage options as the supplemental life premium payment benefit.

H. Dependent Life Premium Payment Benefits

Covered Persons shall have the right to the dependent life insurance benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Document. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions, the procedure for naming beneficiaries and consequences for failure to name a beneficiary, shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for dependent life benefits, he or she may elect any of the dependent life options as the dependent life premium payment benefit.

I. Critical Illness Premium Payment Benefit

Employees who are Covered Persons shall have the right to the critical illness insurance benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Document. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions, shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for critical illness benefits, he or she may elect any of the critical illness coverage options as the critical illness premium payment benefit.

The Employer must contribute the amounts corresponding to the value of the premium payment benefits that Covered Employees select to the benefits selected in Article V. Covered Employees forfeit unused Salary Reduction Contributions and/or Salary Deduction Contributions , if any. Covered Employees may not receive a cash out of Salary Reduction Contributions that are forfeited, nor may Covered Employees apply such forfeitures toward any other Plan benefit.

4.7 Non-Elective Benefits

A. Basic Life/AD&D Benefits

Employees who are Covered Persons shall have the right to the basic life benefits provided under the applicable Incorporated Documents. Such benefits shall be subject to the terms conditions, and limitations set forth in such applicable Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations, exclusions, and the procedure for naming beneficiaries and consequences for failure to name a beneficiary, shall be as set forth in the applicable Incorporated Document.

B. Employee Assistance Benefits

Covered Persons shall have the right to the employee assistance benefits provided under the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Incorporated Document. A description of such benefits, including the amount payable, maximums, and conditions precedent to payment, limitations, and exclusions shall be set forth in the applicable Incorporated Document.

C. Long-Term Disability Benefits

Employees who are Covered Persons who are Exempt and Non-Exempt shall have the right to the long-term disability benefits provided under the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations, and exclusions shall be set forth in the applicable Incorporated Documents.

4.8 Limits for Certain Employees

Benefits payable under the Plan to each highly compensated participant, as defined in Code section 125(e)(1) or highly compensated individual, as defined in Code section 125(e)(2), shall be limited to the extent necessary to avoid violating Code section 125(b)(1), as applicable.

Benefits payable under the Plan to each key employee, as defined in Code section 416(i)(1), shall be limited to the extent necessary to avoid violating Code section 125(b)(2), as applicable.

Benefits payable under the Plan to each highly compensated individual, as defined in Code section 105(h)(5) shall be limited to the extent necessary to avoid violating Code section 105(h)(l) as applicable.

Benefits payable under the Plan to a highly compensated employee, as defined in Code section 414(q), are limited to the extent necessary to avoid violating Code section 129(d)(8). The Employer may determine prior to or during a Plan Year that the salary reductions contributions of a highly compensated employee must be reduced to avoid violating Code section 129(d)(8). Any amounts that are in excess of the Code section 129(d)(8) limit shall be returned to a highly compensated employee in the form of taxable compensation.

4.9 Notification of Premium Payment Amounts

The Company shall provide written notification to eligible Employees of the amount of the premium payment benefits prior to the initial and annual enrollment/election period. The amount of the premium payment benefits shall be the contributions required of the Employee to participate in the group health or welfare benefit plan(s) for which a premium payment benefit is available under the Plan. Any such written notification is hereby incorporated by reference and made part of the Plan.

4.10 Application of Other Plans

Notwithstanding any other provision of the Plan, Covered Employees electing one or more premium payment benefits under the Plan shall be subject to the provisions, conditions, limitations, and exclusions of the Benefit listed in Article IV for which they elect the premium payment benefit.

ARTICLE V

ELECTIONS

5.1 Enrollment for Non-Elective Benefits

All Employees meeting the eligibility requirements of Section 3.1 shall be automatically covered for Benefits described in Section 4.7 and such benefits shall not be subject to the provisions of this Article V.

5.2 Enrollment for Elective Benefits

A. Initial Enrollment/Election

Employees meeting the eligibility requirements of Section 3.1 shall be eligible to elect Benefits described in Section 4.4, 4.5 and 4.6.

B. Annual Enrollment/Election

Approximately 30 days before each Plan Year begins, the Plan Administrator shall conduct an enrollment during which Employees may make new elections or change existing ones for the next Plan Year.

5.3 Salary Reduction/Deduction Agreements

During the applicable election period determined by the Employer, an Employee shall enter into a Salary Reduction Agreement with the Employer if such Employee selects Benefits requiring Employee pre-tax contributions. The Salary Reduction Agreement shall authorize the Employer to reduce the Employee's salary by the amount of required Employee contributions. All elections of Benefits shall be null and void if the Covered Employee fails to execute a Salary Reduction Agreement as provided for herein.

During the applicable election period determined by the Employer, an Employee shall enter into a Salary Deduction Agreement with the Employer if such Employee selects Benefits requiring Employee after-tax contributions. The Salary Deduction Agreement shall authorize the Employer to deduct the amount of required Employee contributions from the Employee's pay on an after-tax basis. All elections of Benefits shall be null and void if the Covered Employee fails to execute a Salary Deduction Agreement as provided for herein.

5.4 Forms and Agreements

Employees may enroll, make elections, and direct their Employer to make Salary Reduction Contributions and/or Salary Deduction Contributions only by filing the appropriate, completed forms or agreements with the Plan Administrator before the deadline described in Section 5.6.

5.5 Default Benefits

The Plan Administrator shall conduct an enrollment during which Employees may make new elections or change existing ones for the next Plan Year. Unless the Plan Administrator approves a supplemental election, as described in Section 5.8(B), a Covered Employee who fails to submit a valid enrollment/election and Salary Reduction Agreement and/or Salary Deduction Agreement, as required in Section 5.4, is deemed to have elected the unreduced compensation benefit described in Section 4.3, and to not have elected the Buy-Out Option described in Section 4.4, the Opt-Out Benefit described in Section 4.5 and to not have elected any Benefits described in Section 4.6.

An Employees enrolling for the first time who fails to submit a valid enrollment/election and Salary Reduction Agreement and/or Salary Deduction Agreement, as required in Section 5.4, is deemed to have elected the unreduced compensation benefit described in Section 4.3 and to not have elected the Buy-Out Option described in Section 4.4, the Opt-Out Benefit described in Section 4.5 and to not have elected any Benefits described in Section 4.6.

Employees who fail to make an election shall receive only the Benefits described in Section 4.7.

5.6 Deadlines

A. Initial Enrollment/Election

For Employees who become eligible after the Effective Date but before the annual enrollment described in Section 5.2(B), the deadline for enrolling and making initial elections is the 30 day period after the Employee becomes eligible in accordance with Section 3.1. Salary Reduction Agreements and/or Salary Deduction Agreements completed by Eligible Employees shall be effective as of the first day of the month following the date on which the Employee becomes eligible in accordance with Section 3.1 and completes the initial enrollment agreement with the Plan Administrator.

B. Annual Enrollment/Election

For Covered Employees and Employees who become eligible as of the first day of a Plan Year, the deadline for enrolling and making elections is the date the Plan Administrator specifies, but no later than the day preceding the first day of the Plan Year to which the enrollment, elections, and Salary Reduction Agreement and/or Salary Deduction Agreement apply.

5.7 Validity of Election Forms

A. Plan Administrator Approval

Enrollments and elections and Salary Reduction Agreement and/or Salary Deduction Agreements take effect only if valid, as determined by the Plan Administrator. Except for supplemental elections described in Section 5.8(B), the Plan Administrator shall substitute the unreduced compensation benefit, described in Section 4.3, for any invalid premium payment benefit election.

B. Remedial Modification or Rejection

The Plan Administrator may modify or reject any enrollment or election and/or Salary Reduction Agreement and/or Salary Deduction Agreement or take other action the Plan Administrator deems appropriate under rules uniformly applicable to similarly situated persons to satisfy nondiscrimination requirements of Code section 125(b). Any remedial modification, rejection, or other action the Plan Administrator takes must be on a reasonable basis that does not discriminate in favor of highly compensated individuals or participants, as defined in Code section 125(e)(1) and (2), respectively, or key employees, as defined in Code section 416(i)(1).

5.8 Changing Elections

A. General Rule

All elections and Salary Reduction Agreements and/or Salary Deduction Agreements stay in force during the entire Plan Year to which they apply unless changed or revoked as provided in this Section 5.8. During annual enrollment, however, Covered Employees may make new benefit elections or change existing ones for the forthcoming Plan Year. Notwithstanding the foregoing, elections and Salary Reduction Agreements for Benefits described in Section 4.6 (E), (F), (G), (H) and (I) are not subject to the rules of this Section 5.8.

B. Supplemental Elections

Section 5.8(A) notwithstanding, the Plan Administrator may approve a supplemental election to correct an enrollment or election form or Salary Reduction Agreement or Salary Deduction Agreement that is invalid for any reason if approval would not violate Code section 125.

C. Revocation of Elections

Except as provided in Section 3.3(C), Covered Employees may revoke elections (including default elections) and Salary Reduction Agreements and Salary Deduction Agreements during a Plan Year only in accordance with the provisions described in this Section 5.8(C). Except for changes made in accordance with

Section 5.8(C)(7) and, changes made pursuant to a HIPAA special enrollment due to initial entitlement to state premium assistance under Medicaid or CHIP or loss of entitlement to Medicaid or a state children’s health insurance program (CHIP), a Covered Employee must make the change within 30 days of the event giving rise to the election change. In the event of a HIPAA special enrollment due to the loss of Medicaid or a state children's health insurance program (CHIP) or initial entitlement to state premium assistance by an Employee, Spouse or Dependent a Covered Employee will have 60 days from the date of the event to make an election change. Notwithstanding the provisions of this Section 5.8(C), an Employee’s or Covered Employee’s ability to elect or revoke certain benefit option mid year may be restricted by the terms of the plan governing that benefit option.

1. Separation from Service

   Covered Employees may revoke elections and Salary Reduction Agreements or Salary Deduction Agreements on separating from the Employer's service. Regardless of previous claims or reimbursements, the Plan Administrator must reimburse a Covered Employee for any amounts the Covered Employee already paid for coverage relating to the period after the effective date of termination of coverage.

2. Change in Status

   A Covered Employee may revoke any election and make a new one if such revocation and new election are both on account of and necessary or appropriate because of a Change in Status.

   Election and Salary Reduction Agreement changes must be consistent with the Change in Status, except for elections:

   (1) Made pursuant to the special enrollment provisions of HIPAA. or

   (2) Made to increase Salary Reduction Contributions in the event the Employee or Dependent elects COBRA coverage.

   For purposes of this paragraph (2), the term consistent means that the Change in Status event must cause the Employee or Employee’s Spouse or Dependent children to gain or lose eligibility under an employer-sponsored benefit offered through this Plan or the plan of the Spouse or Dependent, including a Change in Status that results in an increase or decrease in the number of an Employee’s Dependents who may benefit from coverage under the Plan. The election shall take effect as of the date of the Change in Status.

   The Plan Administrator may require such evidence as it deems necessary to satisfy the consistency requirement imposed by section 125 of the Code.

3. Cost Changes

If the cost of a premium payment benefit increases or decreases during a Plan Year, the Plan may, on a reasonable and consistent basis, automatically make a prospective change to Covered Employees' contributions to reflect the cost of this change.

If the Plan Administrator determines that the increase in cost of such premium payment benefit is significant, however, Covered Employees who have elected that premium payment benefit may either change their Salary Reduction Agreement correspondingly or revoke their premium payment benefit election and — in lieu thereof — elect, prospectively, a premium payment benefit with similar coverage, or may revoke the existing premium payment benefit if no other option providing similar coverage is available. Employees who previously waived participation may elect benefits if the cost of the coverage significantly decreases during the Plan Year.

This opportunity for making new elections does not apply to the Health Care Spending Account Plan and applies to the Dependent Care Spending Account Plan only if a cost increase is imposed by a dependent care provider who is not a relative of the Covered Employee. For purposes of this subparagraph (c), a "relative" is an individual who is related as described in Code section 152(d)(2) (A) through (G), incorporating the rules of Code sections 152(f)(1)(B) and 152(f)(4).

4. Coverage Changes

a. Significant curtailment without a *loss of coverage*

If coverage offered under the Plan is significantly curtailed without a *loss of coverage* during a Plan Year, affected Covered Employees may revoke their election and make a new election on a prospective basis for coverage under another option providing similar coverage. For purposes of this Section 5.8(C)(4), a significant curtailment occurs if there is an overall reduction in coverage generally.

b. Significant curtailment with *loss of coverage*

If coverage offered under the Plan is significantly curtailed to the extent that the Covered Employee experiences a *loss of coverage*, affected Covered Employees may revoke their election and make a new election on a prospective basis for coverage under another option providing similar coverage, or may revoke existing coverage if no other option providing similar coverage is available. For purposes of this Section 5.8(C)(4), a *loss of coverage* means a complete loss of coverage under the benefit option and shall include the elimination of a benefit option, an HMO ceasing to be available

where the individual resides, the individual losing all coverage under the option by reason of an overall lifetime or annual limitation, or other fundamental loss of coverage as determined by the Plan Administrator.

c. Addition or improvement of a benefit option

If the coverage offered under the Plan is significantly improved or if a new benefit option is made available under the Plan, then: (A) a Covered Employee who is enrolled in a benefit option other than the new or significantly improved benefit option may change their election on a prospective basis to elect the new or significantly improved benefit option, or (B) a Eligible Employee who had previously elected to waive coverage under a benefit option may elect to enroll on a prospective basis in the new or significantly improved benefit option. The Plan Administrator, in its sole discretion, will determine whether there has been an addition of, or a significant improvement in, a benefit option in accordance with Internal Revenue Service guidance.

5. Change in Coverage of Employee, Spouse or Dependent under Another Employer's Plan

If the Employee or the Employee's Spouse or Dependent is covered under another plan of the Employer or a plan of the employer of the Employee's Spouse or Dependent, the Employee may make an election change under this Plan in the following situations, provided such election change is on account of and corresponds with a change under the other plan:

a. if the plan year of such other employer plan is different than the Plan Year of this Plan, or

b. if the other employer plan permits the Employee, Spouse or Dependent to make changes for any of the situations described in this Section 5.8(C).

6. Loss of Coverage under Another Health Plan

If an Employee, Spouse or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, the Employee may make a new election on a prospective basis for health coverage provided under this Plan, provided such Employee, Spouse or Dependent is otherwise eligible for coverage under this Plan. For purposes of this Section 5.8(C)(6), a governmental or educational institution shall include the following:

a. A state children's health program (CHIP) under Title XXI of the Social Security Act,

b. A medical program of an Indian Tribal government (as defined in section 7701(a)(40) of the Code), the Indian Health Service, or a tribal organization,

c. A state health benefits risk pool, or

d. A foreign government group health plan.

7. Automatic Adjustment of Election

The election and Salary Reduction Agreement of a Covered Employee who loses a Spouse or Dependent due to death for purposes of a premium payment benefit described in Section 4.4 but fails to make a timely election in accordance with Section 5.8(C)(2)—shall be automatically adjusted in accordance with this Section 5.8(C)(7).

8. Reduction in Work Hours.

Effective September 18, 2014, if there is a change in a Participant's employment status such that the hours of service for which the Participant is scheduled to work for a Participating Employer are reduced to average less than thirty (30) hours per week, and the Participant and his or her covered Dependents remain eligible for health coverage under the plan of the Participating Employer, the Participant may make corresponding changes to his or her election of Benefits and Compensation reduction agreement under Section 3.3(a) to revoke an election of health coverage for the Employee and his or her covered Dependents, and elect coverage under another health plan that provides "minimum essential coverage" as defined under the PPACA. The new election of coverage must take effect no later than the first day of the second month following the month that includes the date the Participant revokes his election of coverage. The Plan may rely on the Participant's representations that he or she and any covered Dependents have enrolled in or intend to enroll in another health plan that provides minimum essential coverage within the foregoing time period.

9. Enrollment in a Health Insurance Marketplace.

Effective September 18, 2014, if a Participant (A) is eligible to change his or her Benefit Package Options during a Special Enrollment Period as determined under Section 9801 of the Code, (B) is eligible for special enrollment rights with respect to a health insurance marketplace established under the PPACA, as defined in 45 CFR Section 155.420(d), or (C) desires to enroll in a plan under a health insurance marketplace during the marketplace's annual open enrollment period, then the

Participant may make corresponding changes to his or her election of Benefits and Compensation reduction agreement under Section 3.3(a) by revoking an election of health coverage for the Employee and his or her Dependents, and electing coverage in a plan under the health insurance marketplace. The new election of coverage through the health insurance marketplace must be effective beginning no later than the day immediately following the last day of the health coverage under the Plan that is being revoked. The Plan may rely on the Participant's representation that he or she and any covered Dependents have enrolled in or intend to enroll in a plan under the health insurance marketplace.

ARTICLE VI

COORDINATION OF BENEFITS

6.1 Applicability

Except as provided in Section 6.9, the following Coordination of Benefits ("COB") provisions apply to this Plan, as outlined in this Article VI, when a Covered Person has health care coverage under more than one Health Care Arrangement.

6.2 COB Definitions

A. "Health Care Arrangement" means any of the following coverages which provides benefits or services to the Covered Person for, or because of, medical, surgical or hospital care treatment:

1. Group, blanket or franchise coverage, whether insured or uninsured;

2. Group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including HMOs;

3. Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;

4. Coverage under government programs and any other coverage required or provided by law other than Medicare or a state plan under Medicaid;

5. Group or individual automobile no-fault coverage;

6. Other arrangements of insured or self-insured group coverage.

The term Health Care Arrangement shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Health Care Arrangements into consideration in determining its benefits and that portion which does not.

B. "Allowable Expense" means a usual and customary item of expense for health care, when the item of expense is covered at least in part by one or more Health Care Arrangements covering the individual for whom the claim is made.

When a Health Care Arrangement provides benefits in the form of services instead of cash payments, the reasonable cash value of each rendered will be considered both an Allowable Expense and a benefit paid.

C. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an individual has no coverage under this Plan.

6.3 Order of Benefit Determination Rules

This Plan determines its order of benefits using the first of the following rules which applies:

A. COB/Non-COB Provision

The benefits of a Health Care Arrangement which does not contain a COB provision always shall be determined before the benefits of a Health Care Arrangement which does contain a COB provision.

B. No Fault Auto Insurance

The benefits of the Health Care Arrangement which covers the person as a beneficiary under a no-fault automobile insurance policy required by law shall be determined prior to this Plan, regardless of whether the no-fault policy has been selected as secondary.

C. Non-Dependent/Dependent

The benefits of the Health Care Arrangement which covers the person as an employee, member or subscriber (that is, other than as a dependent) shall be determined before those of the Health Care Arrangement which covers the person as a dependent.

D. Dependent Child/Parents not Separated or Divorced

Except as stated in Paragraph (D) below, when this Plan and another Health Care Arrangement cover the same child as a dependent of different persons, called "parents":

1. the benefits of the Health Care Arrangement of the parent whose birthday falls earlier in a year are determined before those of the Health Care Arrangement of the parent whose birthday falls later in that year; but

2. if both parents have the same birthday, the benefits of the Health Care Arrangement which covered the parent longer are determined before those of the Health Care Arrangement which covered the other parent for a shorter period of time.

However, if the other Health Care Arrangement does not have the rule described in (1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Health Care Arrangements do not agree on the order of benefits, the rule in the other Health Care Arrangement will determine the order of benefits.

E. Dependent Child/Separated or Divorced Parents

If two or more Health Care Arrangements cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. first, the Health Care Arrangement of the parent with custody of the child;

2. then, the Health Care Arrangement of the spouse of the parent with custody of the child; and

3. finally, the Health Care Arrangement of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Health Care Arrangements of that parent has actual knowledge of those terms, the benefits of that Health Care Arrangement are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

This Plan will not cover the expenses of any child who does not meet the definition of Dependent as defined in Section 2.11, except as may be required pursuant to a qualified medical child support order under section 609(a) of ERISA.

F. Active/Inactive Employee

The benefits of a Health Care Arrangement which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Health Care Arrangement which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Health Care Arrangement does not have this rule, and if, as a result, the Health Care Arrangements do not agree on the order of benefits, this rule is ignored.

G. Continuation Coverage

If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and also under another group plan, the following shall be the order of benefit determination:

1. First, the benefits of a plan covering the person as an employee (or as that employee's dependent);

2. Second, the benefits of coverage under the continuation plan.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

H. Longer-Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the Health Care Arrangement which covered an employee, member or subscriber longer are determined before those of the Health Care Arrangement which covered that person for the shorter time.

I. Medicare Coordination

1. Employees and/or Spouses Age 65 or Older

Unless an active Employee age 65 or older gives the Plan written notice waiving his or her right to Plan benefits, the Plan is Primary. With respect to the spouse who is age 65 or older of an active Employee, unless the Employee gives the Plan written notice waiving Plan benefits, the Plan is primary.

2. Medicare Disabled Covered Persons

If required by law, the Plan is primary with respect to a Covered Person who is also entitled to Medicare because of disability. Otherwise, the Plan is secondary.

3. Covered Persons with End-Stage Renal Disease

For the period required by law, if any, the Plan is primary with respect to a Covered Person entitled to Medicare because of end-stage renal disease. Otherwise, the Plan is secondary.

6.4 Effect on the Benefits of this Plan

A. When this Section Applies

This Section 6.4 applies when, in accordance with Section 6.3, "Order of Benefit Determination Rules", this Plan is a secondary payor of benefits to one or more other Health Care Arrangements. In that event, the benefits of this Plan may be reduced under this Section. Such other Health Care Arrangement or Arrangements are referred to as "the other Arrangements" in (B) immediately below.

B. Reduction in this Plan's Benefits

The benefits that would be payable under this Plan in the absence of the COB provisions specified in this Article VI will be reduced by the benefits payable under the other Arrangements for the expenses covered in whole or in part under this Plan. This applies whether or not claim is made under a Health Care Arrangement.

When a Health Care Arrangement provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an expense incurred and a benefit payable.

6.5 Limitation of Benefits

In applying this Article's provisions, the Plan does not pay health care benefits in an amount greater than it would have if it were primary. Furthermore, in determining what benefits are paid from this Plan, payments from this Plan shall not exceed the amount that this Plan would pay if the primary payor.

6.6 Right to Receive and Release Necessary COB Information

The Company has the right to obtain any information necessary to apply the COB provisions of this Article VI. The Company has the right to obtain COB information from or give that information to any other organization or person involved in the administration of the COB provisions of this Plan or any other Health Care Arrangement. The Company need not tell, or get the consent of, any person prior to obtaining that information. Each person claiming benefits under this Plan must give the Company any information it needs to process the claim.

6.7 Facility of Payment

A payment made under another Health Care Arrangement may include an amount which should have been paid under this Plan. If it does, the Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

6.8 Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under the COB provisions specified in this Article VI, it may recover the excess from one or more of:

A. the persons it has paid or for whom it has paid;

B. insurance companies; or

C. other Health Care Arrangements, including Workers' Compensation.

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

6.9 Governing Provisions

When the provisions describing coordination of benefits are set forth in an applicable Incorporated Document, such Incorporated Document shall govern except to the extent the provisions fail to establish order of responsibility, in which case the provisions of this Article VI shall govern.

ARTICLE VII

COBRA CONTINUATION COVERAGE

7.1 Eligibility for Continuation Coverage

The provisions contained in this Article VII apply only to the medical, dental, employee assistance and health care spending account benefits provided under the Plan. The provisions of this Article VII do not govern to the extent provided in Section 7.9.

Certain Employees and Dependents shall have the right to purchase continuation coverage under this Plan in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, Title X (COBRA), provided such individuals were Covered Persons under the Plan on the date immediately preceding the date of a Qualifying Event or become Covered Persons during the continuation period because such Dependent is born to or placed for adoption with the Employee.

7.2 Definitions

For purposes of this Article VII, the following terms have the following meanings:

A. "Employee" means a person who is (or was) covered under the Plan by virtue of the person's performing services for the Employer on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage.

B. "Dependent" means, with respect to an Employee as defined in this Section 7.2, any individual who, on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage, is covered under the Plan as (1) the Spouse of such Employee or (2) the Dependent child of such Employee. The term Dependent shall include any child born to or placed for adoption with the Employee during the continuation period.

C. "Qualified Beneficiary" means an Employee or Dependent as defined in this Section 7.2 but shall not mean Dependents defined in Section 7.7(B), except that the term Qualified Beneficiary shall include Dependents born to or placed for adoption with the Employee during the continuation period.

D. "Qualifying Event" means any of the following, the occurrence of which would result in loss of coverage under the Plan were it not for the right to purchase COBRA continuation coverage:

   1. for Employees, termination of employment or loss of eligibility due to reduction in hours worked by the Employee;

   2. for Dependents:

      a. death of the Employee;

b. divorce of the Employee and spouse;

c. reduction in hours worked by the Employee or termination of employment by the Employee for any reason;

d. entitlement of the Employee to benefits under Title XVIII of the Social Security Act (relating to Medicare); or

e. ceasing to qualify as a Dependent child under the Plan.

The Qualifying Event shall be deemed to occur on the date of the Qualifying Event — not on the date coverage ends because of the Qualifying Event.

7.3 Loss of Eligibility for Continuation Coverage

A Qualified Beneficiary shall not be eligible for COBRA continuation coverage unless:

A. the Company or Plan Administrator is notified of the election of COBRA continuation coverage, on a form provided for that purpose, within 60 days of the later of:

1. the date the Qualified Beneficiary's coverage under the Plan would otherwise terminate by reason of an event described in Section 7.2(D); or

2. the date notice of eligibility is sent to the individual in accordance with Section 7.5(C); and

B. the Qualified Beneficiary pays the initial required premium, as set forth in Section 7.8, no later than the date 45 days after the date on which COBRA continuation coverage was elected.

Until expiration of the election period, a Qualified Beneficiary may change or revoke any election. Failure to elect COBRA continuation coverage within the prescribed election period shall result in a waiver of the right to COBRA continuation coverage.

7.4 Termination of COBRA Continuation Coverage

COBRA continuation coverage shall terminate on the date on which the earliest of the following occurs:

A. the last day of the month preceding the date the Qualified Beneficiary fails to pay a subsequent required premium within 30 days of the date it is due;

B. the date the Qualified Beneficiary first becomes, after the date of making a COBRA election, entitled to Medicare;

C. the date the Qualified Beneficiary first becomes, after the date of making a COBRA election, covered under another group health plan, as defined in Code

section 5000(b)(1), not containing a limitation or exclusion as to any pre-existing condition of such individual (other than such an exclusion or limitation which does not apply to, or is satisfied by, such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996);

D. 36 months from the date on which a Qualifying Event described in Sections 7.2(D)(2)(a), 7.2(D)(2)(b), 7.2(D)(2)(d), or 7.2(D)(2)(e) occurs;

E. 18 months from the date on which a Qualifying Event described in Sections 7.2(D)(1) or 7.2(D)(2)(e) occurs. If a Qualifying Event described in Sections 7.2(D)(2)(a), 7.2(D)(2)(b), 7.2(D)(2)(d), or 7.2(D)(2)(c) occurs subsequent to a Qualifying Event described in Section 7.2(D)(2)(c), an additional period of coverage shall be allowed for Dependents who have properly and timely elected and paid for COBRA continuation coverage; but, in no event shall the sum of the first and second periods of coverage exceed 36 months from the date of the first Qualifying Event giving rise to the Qualified Beneficiary's eligibility for COBRA continuation coverage;

F. the date the Company terminates all group health plans;

G. in the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled (i) at the time of the Qualifying Event or (ii) at any time during the first 60 days of continuation coverage, the 18-month period set forth in Section 7.4(E) shall be extended to 29 months; provided that such individual notifies the Plan Administrator of such determination in accordance with Section 7.5(D) before the end of such 18-month period; and provided further that if the Qualified Beneficiary does not remain disabled during the extended period, coverage shall cease with the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled;

H. in the case of a Qualifying Event described in Section 7.2(D)(2)(c) that occurs less than 18 months after the date the Employee becomes entitled to Medicare, 36 months from the date the Employee becomes entitled to Medicare; or

I. for the Health Care Spending Account Plan, the last day of the Plan Year in which the Qualifying Event occurs.

7.5 Notice Requirements

A. The Employer shall notify the Plan Administrator of the occurrence of an event described in Sections 7.2(D)(1), 7.2(D)(2)(a), 7.2(D)(2)(c), and 7.2(D)(2)(d), within 30 days of the date of the described event.

B. The Qualified Beneficiary shall be responsible for notifying the Plan Administrator of the occurrence of an event described in Sections 7.2(D)(2)(b), or 7.2(D)(2)(e) within 60 days of the date of the described event.

C. The Plan Administrator shall provide notice to Qualified Beneficiaries of their COBRA continuation coverage rights within 14 days of the date it receives the notice described in Sections 7.5(A) and (B).

D. A Qualified Beneficiary, who is determined under Title II or XVI of the Social Security Act to have been disabled at any time within the first 60 days of the continuation period, shall be responsible for notifying the Plan Administrator of such determination within 60 days after the date of such determination, but in no event later than the end of the 18-month period set forth in Section 7.4(E). Such Qualified Beneficiary further shall be responsible for notifying the Plan Administrator of any final determination under such Title(s) that he or she is no longer disabled, within 30 days of the date of such determination.

E. At the commencement of coverage under the Plan, the Plan Administrator shall provide each Employee or Spouse who is a Covered Person with notice of their rights under COBRA.

F. The Plan Administrator shall provide notice to each Qualified Beneficiary of any termination of COBRA continuation coverage that takes effect earlier than the end of the maximum period of COBRA continuation coverage applicable to the Qualified Beneficiary.

G. The Plan Administrator shall provide notice to each Employee, Spouse or Dependent of the unavailability of COBRA continuation coverage if the Plan Administrator determines after receiving notice of a Qualifying Event that the Employee, Spouse or Dependent is not entitled to COBRA continuation coverage.

7.6 Coverage Available for Continuation

A Qualified Beneficiary may elect to continue receiving the health care coverage (as defined in COBRA regulations) he or she was receiving immediately before the event giving rise to the right to elect COBRA continuation coverage. If coverage provided to similarly situated active Employees is changed or eliminated, COBRA continuation coverage also shall be changed or eliminated. If the Company terminates the Plan but continues to maintain one or more other group health plans, as defined in Code section 5000(b)(l), COBRA continuation coverage recipients may elect coverage under one of those other group health plans. A Qualified Beneficiary may elect to continue to receive coverage for the level of reimbursement, if any, that the individual had in effect under his or her Health Care Spending Account immediately before the Qualifying Event after reflecting debits for health care reimbursements made up to the Qualifying Event.

7.7 Election Rules

A. Scope of Election

Each affected Qualified Beneficiary generally shall have an independent right to elect or reject COBRA continuation coverage under this Article VII; provided, however, that in the event an Employee or his or her Spouse makes an election to continue coverage on behalf of the other or on behalf of any other Qualified Beneficiary, such election shall be binding on such other party; and provided further, that in the event the Qualified Beneficiary is a minor or an incapacitated person, the parent or legal guardian of such minor or the legal representative of such incapacitated person shall have the right to elect or reject continuation coverage on behalf of such minor or incapacitated person, and any such election or rejection of coverage shall be binding on such minor or incapacitated person. Each Qualified Beneficiary is entitled to a separate election with respect to any choice of coverages available under the Plan.

B. After Acquired Dependents

A Qualified Beneficiary eligible for COBRA continuation coverage may elect to cover Dependents (as defined in Section 7.2(B)) acquired after the date of eligibility described under Section 7.3 to the same extent as Covered Persons, provided the Company or Plan Administrator is notified of the election to cover such Dependent(s) in the manner and within the time set forth in an applicable document incorporated by reference under the Plan, except that in no event shall notice be required within a period of less than 30 days. Such newly acquired Dependent(s), other than Qualified Beneficiaries defined in Section 7.2(C), shall have no independent right to COBRA continuation coverage. Failure to notify the Company or Plan Administrator within the prescribed time shall result in a waiver of the right to elect COBRA continuation coverage for such newly acquired Dependent(s).

C. Open Enrollment Periods

During an open enrollment period occurring during the COBRA coverage period, a Qualified Beneficiary may elect to cover Dependents not previously covered, subject to the terms and conditions set forth in the applicable document incorporated by reference under the Plan. This subsection (C) shall not apply to Health Care Spending Account benefits.

7.8 Required Premium

In order to receive COBRA continuation coverage, Qualified Beneficiaries shall agree, on forms furnished by the Plan Administrator, to pay any required premiums to the Plan and shall make such premium payments when and as required. All premiums other than the initial premium shall be due on the first day of the calendar month. The amount of the premium shall be no more than 102 percent of the cost of coverage. In the case of a Qualified Beneficiary who is determined under Title I or XVI of the Social Security Act to have been disabled at any time within the first 60 days of continuation coverage, the cost of coverage for the 19th month through the 29th month of coverage shall be no more than 150 percent of the cost of coverage. Effective July 1, 2017, a Qualified Beneficiary that experiences a Qualifying Event described in 7.2(D)(2)(a), shall be eligible to receive an Employer provided COBRA premium subsidy for a period of the first ninety (90) days of continuation coverage. After the ninety (90) day period expires, the Qualified Beneficiary shall pay any required premiums to the Plan and shall make such premium payments when and as required, should the Qualified Beneficiary continue COBRA coverage. Notwithstanding the foregoing, the cost of coverage shall not exceed the maximum, nor be changed more frequently than, permitted by law.

7.9 Governing Provisions

When the provisions for COBRA continuation coverage are set forth in an applicable Incorporated Document, such applicable Incorporated Document shall govern except to the extent such language fails to comply with requirements of applicable law or fails to determine the right or liability of the party, in which case the provisions of this Article VII shall govern.

ARTICLE VIII

CONTRIBUTIONS, FUNDING AND PLAN ASSETS

8.1 Contributions

A. Employer Contributions

The Employer shall pay premium payment benefits listed in Section 4.5 to the Employer-sponsored plans to which such benefits are payable provided that the Covered Employee shall authorize Salary Reduction Contributions in a corresponding amount pursuant to Section 8.1(B)(2).

The Employer shall make Employer contributions for benefits listed in Section 4.6 to the Employer-sponsored plans to which such benefits are payable.

Notwithstanding any contrary Plan provision, an Employer is not obligated to contribute to the Plan after it is terminated except to the extent required to pay benefits outstanding on the date the termination is adopted or, if later, effective.

B. Salary Reduction and/or Salary Deduction Contributions

As a condition of Plan participation, Employees must agree to direct the Employer to:

1. not reduce their compensation and not provide premium payment benefits pursuant to Section 4.6, or

2. reduce their compensation and make Salary Reduction Contributions and/or Salary Deduction Contributions to the plan(s) governing their selected premium payment benefits.

Any election of premium payment benefits shall be null and void unless the Employee authorizes a Salary Reduction Agreement and/or a Salary Deduction Agreement as provided for herein. An Employer must take Salary Reduction Contributions and/or Salary Deduction Contributions and apply them as directed, except that the Employer may not apply a Salary Reduction Contribution or a Salary Deduction Contribution for a selected premium payment benefit to any other premium payment benefit nor may a Salary Reduction Contribution or a Salary Deduction Contribution be applied during a subsequent Plan Year to any participating plan that provides benefits or coverage. Any such Salary Reduction Agreements and/or a Salary Deduction Agreements are hereby incorporated by reference into the Plan as if set forth in full herein.

C. Priority of Contributions

Contributions shall be deemed to come first from amounts contributed by Covered Employees and then from amounts contributed by the Employer.

D. COBRA Contributions

To the extent a former Covered Employee, Dependent or Spouse has exercised his or her continuation rights under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) with respect to benefits described in Sections 4.6 (A), (B), (C) and 4.7 (B), the Plan shall accept contributions from such individuals as COBRA premiums.

8.2 Funding

A. Funding Policy

The Employer shall establish and carry out, and may revise from time to time, the funding policy for the Plan.

B. Funding Mechanism

Contributions from the Employer and/or Employees may be held under or paid to one or more of the following vehicles: insurance policies or arrangements, arrangements with health maintenance organizations, or trust funds established by the Employer. In addition, benefits may be paid directly from the general assets of the Employer. Benefits provided through insurance or pursuant to an arrangement with a health maintenance organization shall be only paid by the Insurance Employer issuing the insurance policy or by the health maintenance organization. The Employer shall have no liability for benefits provided through insurance or pursuant to an agreement with a health maintenance organization.

8.3 Plan Assets

The Employer shall make payments provided for in Section 8.1(A) from its general assets. The Employer shall make payments provided for in Section 8.1(B) and (D) by collecting Employee contributions and COBRA contributions and transmitting such amounts to the applicable benefits described in Article IV.

8.4 Treatment of Certain Policy Payments

Where an insurance policy provides for payment of premiums directly from the Employer, unless the insurance policy states otherwise, payable dividends, retroactive rate adjustments, or experience refunds are not plan assets. These dividends, retroactive rate adjustments, or experience refunds are Employer property, which the Employer may retain to the extent they do not exceed the Employer’s aggregate contributions to Plan cost made from its own funds.

ARTICLE IX

CLAIM AND PAYMENT PROCEDURES

9.1 General Claims Procedures

Except as hereinafter provided, the provisions of this Section shall apply to every claim for a benefit under the Plan regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred.

These provisions shall not apply to the extent that claims and appeals procedures are set forth differently in an Incorporated Document, except to the extent that claims and appeals procedures set forth in an Incorporated Document fail to comply with requirements of applicable law, in which case the provisions of this Article IX shall govern. In addition, the provisions of this Article IX shall not be interpreted so as to override applicable state laws that are more protective of Covered Persons' rights with respect to claims and appeals under ERISA plans, to the extent such state laws are not preempted by ERISA.

Claim procedures for the Dependent Care Spending Account shall be as modified in Article VI of Appendix A.

Claim procedures for the Health Care Spending Account shall be as modified in Article VI of Appendix B.

9.2 Claim Administrator

The Plan Administrator and/or the Company shall have the authority to appoint, remove, and replace one or more Claim Administrators. A Claim Administrator shall have the duties, powers, and responsibilities set forth herein. In the absence of such an appointment and except as hereinafter provided, the Plan Administrator shall also be the Claim Administrator.

Claims with respect to benefits provided on an insured basis shall be determined by the insurance company issuing the policy or agreement as Claim Administrator, except that, if the Employer and insurance company so agree in writing, the Plan Administrator shall retain final authority over the disposition of any review pursuant to Section 9.9.

With respect to claims for benefits provided on a self-funded basis, the Plan Administrator shall retain final authority over the disposition of any review pursuant to Section 9.9 unless otherwise delegated to a Claim Administrator in an Incorporated Document.

9.3 Claims Administration

The Claim Administrator shall have the duty to receive and review claims for benefits under the Plan; to determine what amount, if any, is due and payable under the terms and conditions of the Plan; to make or authorize appropriate disbursements of benefit payments to persons entitled thereto; to inform the Company or any other third party, as appropriate,

of the amount of such benefits; to make claims decisions under the terms of the Plan; and to provide a full and fair review to any individual whose claim for benefits has been denied in whole or in part, except as described in Section 9.2 as applied to self-funded benefits.

9.4 Claimants

A Covered Person (or his or her duly authorized representative) may file a claim for benefits to which such claimant believes he or she is entitled.

9.5 Claim Forms

The Claim Administrator shall furnish to a claimant, upon request, the form(s) required for filing a claim for benefits under the Plan.

9.6 Deadline for Filing a Claim

No claim for benefits shall be payable unless a properly completed claim for, including all necessary documentation of services or supplies received, is received by the Plan Administrator within the timeframe set forth in the applicable Incorporated Document. Failure to submit a properly completed claim form within the prescribed period shall neither invalidate nor reduce a claim if it is shown that it was not reasonably possible to furnish the claim form within that time and that the claim form was submitted as soon as reasonably possible.

9.7 Proof of Claim

As a condition of receiving a Plan benefit and as often as the Plan Administrator determines is reasonably necessary, a claimant must submit such evidence as the Plan Administrator shall require that a claim is reimbursable under the terms of the Plan.

9.8 Decision on the Claim

The following rules shall apply to claims filed with respect to an ERISA Benefit under the Plan. Unless otherwise specified in an applicable Incorporated Document, these claim procedures will also apply to any non-ERISA Benefit under the Plan.

A. Any time an application for benefits, other than health and disability benefits is wholly or partially denied, the claimant shall be given written notice of such action within a reasonable period of time but not later than 90 days after the claim is received by the plan, unless special circumstances require an extension of time for processing. If there is an extension, the claimant shall be notified of the extension and the reason for the extension within the initial 90-day period. The extension shall not exceed 180 days after the claim is filed.

If a claim is denied, in whole or in part, the claimant shall be notified of the denial in writing. The notice of denial shall contain the following information:

a. the specific reason(s) for the denial;

b. a reference to the specific provision(s) in the Plan on which the denial is based;

c. a description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed;

d. a description of the Plan's claim and appeal procedures and applicable timeframes; and

e. a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the Plan's appeal procedure (set forth below) has been exhausted.

B. Any time an application for disability benefits as described in Sections 4.6 (E) or (F) or 4.7 (C) is wholly or partially denied, the claimant shall be given written notice of such action within a reasonable period of time, no later than 45 days after the claim is received by the plan, unless the Claim Administrator determines that an extension of up to 30 days is necessary due to matters beyond the Plan's control. If there is an extension, the claimant shall be notified, before the initial 45-day period of time expires, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The 30-day extension period is tolled until the claimant responds to any information request. A second 30-day extension is also permitted if the Claim Administrator determines that, due to matters beyond the Plan's control, a decision cannot be rendered within the first extension period. In that case, the claimant shall be notified, before the end of the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. Such extension notices 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 45 days within which to provide the specified information.

If a claim is denied, in whole or in part, the claimant shall be notified of the denial in writing. The notice of denial shall contain the following information:

a. the specific reason(s) for the denial;

b. a reference to the specific provision(s) in the Plan on which the denial is based;

c. a description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed;

d. a description of the Plan's claim and appeal procedures and applicable timeframes; and

e. a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the Plan's appeal procedure (set forth below) has been exhausted;

f. if any internal rules, guidelines, protocols or similar criteria were used as a basis for the denial, either the specific rule, guideline, protocol, or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and

g. for denials based on medical necessity, experimental treatment, or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

C. The following rules shall apply to medical, dental, employee assistance plan or health care spending account benefits except that claims for benefits described in Section 4.6 (C) shall be considered "post-service" only.

1. Urgent Care Claims – Claims for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or, in the judgment of a physician, would subject the patient to severe pain that cannot be adequately managed otherwise.

The Claim Administrator shall notify the claimant of the Plan's determination not later than 72 hours after receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claim Administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claim Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but no later than 48 hours after the earlier of the Plan's receipt of the specified information or the end of the period afforded the claimant to provide the specified additional information.

2. Pre-service Claims – Claims which must be decided before a patient will be afforded access to health care (e.g., preauthorization requests).

The Claim Administrator shall notify the claimant of the Plan's determination not later than 15 days after receipt of the claim. This period may be extended by 15 days, provided the Claim Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the Plan and notifies the claimant within the initial period of the circumstances requiring the extension and the date by which the Plan

expects to render a decision. If such an extension is necessary due to the claimant's failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information. If the claim is improperly filed, the Claim Administrator shall notify the claimant as soon as possible, but not later than five (5) days after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

3. Post-service Claims – Claims involving the payment or reimbursement of costs for medical care which has already been provided.

   For non-urgent post-service health claims, the Plan has up to 30 days, to evaluate and process claims for benefits covered by ERISA. The 30-day period begins on the date the claim is first filed. This period may be extended by 15 days provided the Claim Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the Plan and notifies the claimant within the initial period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. In addition, the notice of extension must include 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 45 days from receipt of the notice within which to provide the specified information.

4. Concurrent Care Claims – Claims where the Plan has previously approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments.

   Concurrent care claims may fall under any of the other three categories, depending on when the appeal is made. However, the Plan must give the claimant sufficient advance notice to appeal the claim before a concurrent care decision takes effect.

5. Notification of Denial - applicable to all health claims

   An "adverse benefit determination" is a denial, reduction or termination of a benefit, failure to provide or pay for (in whole or in part) a benefit, a denial to participate in the Plan, or a claim denial on the grounds that the treatment is experimental, investigational or not medically necessary. This also includes concurrent care determinations. In the event of an adverse benefit determination, the claimant will receive notice of the determination.

If a claim is denied, in whole or in part, the claimant shall be notified of the denial in writing. The notice of denial shall contain the following information:

a. the specific reason(s) for the denial;

b. a reference to the specific provision(s) in the Plan on which the denial is based;

c. a description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed;

d. a description of the Plan's claim and appeal procedures and applicable timeframes;

e. a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the Plan's appeal procedure (set forth below) has been exhausted;

f. if any internal rules, guidelines, protocols or similar criteria were used as a basis for the denial, either the specific rule, guideline, protocol, or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;

g. for denials based on medical necessity, experimental treatment, or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and

h. For adverse determinations involving urgent care, the notice will also include a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

9.9 Right to Appeal

A claimant whose claim for benefits under the Plan has been denied, in whole or in part, shall have the right to appeal the denial.

The following rules shall apply to claims filed with respect to an ERISA benefit under the Plan. Unless otherwise specified in an applicable Incorporated Document, these claim appeal rules will also apply to any non-ERISA Benefit under the Plan.

A. A claimant who has had a claim for benefits, other than the health and disability benefits as denied by the Claim Administrator or is otherwise adversely affected by action of the Claim Administrator, shall have the right to request review of the

claim. Such request must be in writing and must be made within 60 days after such claimant is advised of the Claim Administrator's action. The requested review must take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. If written request for review is not made within the 60-day period, the claimant shall forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all relevant information and submit issues, comments, documents, records, and other information in writing.

The Claim Administrator or Plan Administrator or its delegate, as applicable, shall then review the claim. It may hold a hearing if it deems it necessary and shall issue a written decision reaffirming, modifying, or setting aside its former action within a reasonable period of time, but not later than 60 days after receipt of the written request for review, unless the Plan Administrator determines that special circumstances, such as a hearing, require an extension. The claimant shall be notified in writing of any such extension within 60 days following the request for review, and such extension shall not exceed 60 days from the end of the initial period.

A copy of the review determination shall be furnished to the claimant. If the claim is denied, the review determination notice shall contain the following information:

a. the specific reason(s) for the denial;

b. a reference to the specific provision(s) in the Plan on which the denial is based;

c. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access and copies of all relevant information;

d. a statement of the claimant's right to bring a civil action under section 502(a) of ERISA;

e. a description of any voluntary appeals procedures offered by the Plan, if any; and

f. a statement that the claimant has the right to obtain information about the voluntary appeals process, if any, and information as to how the claimant may obtain information about alternative dispute resolution options from the Department of Labor or state regulators.

The decision shall be final and binding upon the claimant and all other persons or entities involved, except to the extent that the Plan provides for a voluntary appeals procedure subsequent to this appeals process, or the decision is subject to judicial review.

B. A claimant who has had a claim for disability benefits as described in Sections 4.6 (E) or (F), or 4.7 (C) wholly or partially denied by the Claim Administrator or is otherwise adversely affected by action of the Claim Administrator, shall have the right to request review of the claim. Such request must be in writing and must be made within 180 days after such claimant is advised of the Claim Administrator's action. If written request for review is not made within the 180-day period, the claimant shall forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all relevant information and submit issues and comments in writing.

The Claim Administrator or Plan Administrator or its delegate, as applicable, shall then review the claim. It shall issue a written decision reaffirming, modifying, or setting aside its former action within a reasonable period of time, but not later than 45 days after receipt of the written request for review, or an additional 45 days if the Plan Administrator determines that special circumstances require an extension. The claimant shall be notified in writing of any such extension before the initial period of time expires, and such notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review. The extension period is tolled until the claimant responds to any information request.

A copy of the review determination shall be furnished to the claimant. If the claim is denied, the review determination notice shall contain the following information:

a. the specific reason(s) for the denial;

b. a reference to the specific provision(s) in the Plan on which the denial is based;

c. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access and copies of all relevant information;

d. a statement of the claimant's right to bring a civil action under section 502(a) of ERISA;

e. a description of any voluntary appeals procedures offered by the Plan, if any;

f. a statement that the claimant has the right to obtain information about the voluntary appeals process, if any, and information as to how the claimant may obtain information about alternative dispute resolution options from the Department of Labor or state regulators;

g. if any internal rules, guidelines, protocols or similar criteria were used as a basis for the denial, either the specific rule, guideline,

protocol, or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and

h. for denials based on medical necessity, experimental treatment, or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

The Plan will provide for the identification of experts whose advice was obtained on behalf of Plan in connection with an adverse determination, without regard to whether the advice was relied on in making determination.

In deciding an appeal of any adverse benefit determination based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such individual shall not have been consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual. In deciding an appeal, no deference will be afforded to the initial adverse benefit determination and the review of the appeal will 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.

The decision shall be final and binding upon the claimant and all other persons or entities involved, except to the extent that the Plan provides for a voluntary appeals procedure subsequent to this appeals process, or the decision is subject to judicial review.

C. A claimant who has had a claim for medical, dental, vision, employee assistance plan or health care spending account benefits as described in Sections wholly or partially denied by the Claim Administrator or is otherwise adversely affected by action of the Claim Administrator, shall have the right to request review of the claim, except that appeals of adverse benefit determination of benefits described in Section 4.6 (C) shall be considered "post-service" only. Such request must be in writing and must be made within 180 days after such claimant is advised of the Claim Administrator's action. If written request for review is not made within the 180-day period, the claimant shall forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all relevant information and submit issues and comments in writing.

The Claim Administrator or Plan Administrator or its delegate, as applicable, shall then review the claim. It shall issue a written decision reaffirming, modifying, or setting aside its former action within a reasonable period of time, but not later than:

1. for urgent health claims, as soon as possible considering the medical situation, but no later than 72 hours,

2. for pre-service claims, within a reasonable period of time given the medical situation, but no later than 30 days (or 15 days following each appeal if there are two mandatory appeals),

3. for post-service claims, within a reasonable period of time, but not later than sixty (60) days after receipt of the request for review (or 30 days following each appeal if there are two mandatory appeals).

A copy of the review determination shall be furnished to the claimant. If the claim is denied, the review determination notice shall contain the following information:

a. the specific reason(s) for the denial;

b. a reference to the specific provision(s) in the Plan on which the denial is based;

c. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access and copies of all relevant information;

d. a statement of the claimant's right to bring a civil action under section 502(a) of ERISA;

e. a description of any voluntary appeals procedures offered by the Plan, if any;

f. a statement that the claimant has the right to obtain information about the voluntary appeals process, if any, and information as to how the claimant may obtain information about alternative dispute resolution options from the Department of Labor or state regulators;

g. if any internal rules, guidelines, protocols or similar criteria were used as a basis for the denial, either the specific rule, guideline, protocol, or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;

h. for denials based on medical necessity, experimental treatment, or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and

i. for adverse determinations involving urgent care, the notice will also include a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

The Plan will provide for the identification of experts whose advice was obtained on behalf of Plan in connection with an adverse determination, without regard to whether the advice was relied on in making determination.

In deciding an appeal of any adverse benefit determination based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such individual shall not have been consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual. In deciding an appeal, no deference shall be afforded to the initial adverse benefit determination and the review of the appeal 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.

The decision shall be final and binding upon the claimant and all other persons or entities involved, except to the extent that the Plan provides for a voluntary appeals procedure subsequent to this appeals process, or the decision is subject to judicial review.

9.10 Legal Remedy

Before pursuing a legal remedy, a claimant shall first exhaust all claims, review, and appeals procedures required under the Plan

9.11 Third Party Liability Claims

A. This Section 9.11 shall govern with respect to Plan benefits for injuries or illnesses of Covered Persons related to a third party's actions or inactions. To the extent that conflicting subrogation or recovery provisions exist in an insurance contract which is an Incorporated Document, such provisions in the insurance contract shall govern.

B. Subrogation

If a Covered Person becomes injured or ill because of the actions or inactions of a third party, the Plan shall have the right to pursue a claim against the third party for expenses paid by the Plan related to such injury or illness. If so requested by the Claim Administrator, the Covered Person (or if a minor, his or her parent or legal guardian) shall:

1. provide proof, satisfactory to the Claim Administrator, that no right, claim, interest or cause of action against a third party has been, or will be, discharged or released without the written consent of the Claim Administrator;

2. execute a written agreement assigning to the Plan all rights, claims, interests, and causes of action that the Covered Person has against a third party in connection with the expenses paid by the Plan;

3. authorize the Plan, in writing, to sue, compromise or settle, in the Covered Person's name or otherwise, all rights, claims, interests, or causes of action to the extent of benefits paid by the Plan and shall do nothing to prejudice the rights given to the Plan under this section; and

4. agree, in writing, to assist the Plan in prosecuting any rights, interests, claims, or causes of action that have been assigned to the Plan against a third party, including, if requested by the Claim Administrator or Plan Administrator, the institution of a formal proceeding against a third party.

C. Plan's Right of Recovery

If a Covered Person becomes injured or ill because of the actions or inactions of a third party, the Plan shall have the right to recover related Plan expenses out of any payments made by (or on behalf of) the third party (whether by lawsuit, settlement, or otherwise) to a Covered Person (or his or her assignee). The Plan's right of recovery applies to the extent the Plan has paid expenses related to the injury or illness, regardless of whether any related settlement or other third-party payment states that the payment (all or part of it) is for health care expenses. By accepting Plan benefits to pay for treatments, devices or other products or services related to such injury or illness, Covered Person agrees to place such third-party payments in Covered Person's separate identifiable account (in an amount equal to related expenses paid by the Plan or, if less, the full third-party payment amount) and that the Plan has an equitable lien on such funds, without regard to whether the Covered Person has been made whole or fully compensated for the injury or illness. Covered Person also agrees to serve as a constructive trustee over the funds until the time they are paid to the Plan. Covered Person further agrees to cooperate with the Plan's recovery efforts and do nothing to prejudice the Plan's recovery rights. The Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) incurred in obtaining the funds.

D. Enforcement of Plan's Subrogation and Recovery Rights

Should it be necessary for the Plan to institute proceedings against the Covered Person for failure to reimburse the Plan or to otherwise honor the Plan's equitable interest in obtaining amounts described in this Section 9.11, the Covered Person shall be liable for the costs of collection relating to such failure, including reasonable attorney's fees.

The Plan shall have the right to offset future benefits to which a claimant (or a Covered Person through whom the claimant derives his or her claim) may be entitled, until the amount otherwise due the Plan under this Section 9.11, plus interest, has been received by the Plan.

The Plan's rights under this Section 9.11 shall be enforceable regardless of whether the third party admits liability for the injury or illness to a Covered Person, and shall remain enforceable against the heirs and estate of any Covered Person.

9.12 Payment Procedures

A. Payment of Claim

Subject to Section 12.4, benefits shall be payable to the claimant upon establishment of the right thereto. Notwithstanding the foregoing, if a claimant is adjudicated bankrupt or purports to anticipate alienate, sell, transfer, assign, pledge, encumber, or charge any benefit payable under the Plan, voluntarily or involuntarily, the Plan Administrator, in its sole discretion, may hold or cause to be held, or apply such payment of benefit, or any part thereof, to or for the benefit of such claimant as the Plan Administrator deems appropriate.

B. Facility of Payment

If a claimant dies before all amounts payable under the Plan have been paid, or if the Plan Administrator determines that the claimant is a minor or is incompetent or incapable of executing a valid receipt and no guardian or legal representative has been appointed, or if the claimant fails to provide the Plan with a forwarding address, the amount otherwise payable to the claimant may be paid to any other person or institution reasonably determined by the Plan Administrator to be entitled equitably thereto and without prejudice therefor. Any payment made in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

C. Forfeiture

The Plan Administrator shall take reasonable steps to ascertain the whereabouts of a claimant so as to affect delivery of benefits payable under the Plan. If a claimant has not collected benefits payable to him or her within 15 months from the date the claim was filed, the Plan Administrator may, three months after sending by certified mail a written notice of benefits to the last known address of such claimant as shown on the records of the Administrator, deem the claimant's right to such benefit waived. Upon such waiver, the Plan shall have no liability for payment of the benefit otherwise payable.

9.13 External Review For purposes of any coverage that is subject to PPACA and is not a Grandfathered Plan, the Plan or Claims Administrator will comply with the applicable requirements of any external review process that applies under federal or State law. For such coverage that is self-funded, the Plan will comply with the procedures set forth in Department of Labor Technical Release 2010-01, as modified by Technical Release 2011-02, until those procedures are superseded by other guidance and the Plan will begin complying with any superseding guidance on or before the date that guidance becomes applicable to such coverage under the Plan. Notwithstanding the foregoing, within 45 days

after receipt of the external review request, written notice of the final external review decision must be provided.

ARTICLE X

ADMINISTRATION

10.1 Plan Administrator

The Company shall appoint a person, entity or committee to serve as Plan Administrator. In the absence of such appointment, the Employer shall be the Plan Administrator. The Plan Administrator shall be the "named fiduciary" for purposes of ERISA.

10.2 Plan Administrator’s Duties

The Plan Administrator shall:

A. manage and carry out the Plan's operation and administration according to the Plan's terms and for Covered Employees' exclusive benefit;

B. maintain:

    1. whatever records and data are necessary or desirable for the Plan's proper operation and administration, and

    2. the Plan's governing documentation for inspection by anyone who participates or is eligible to participate in the Plan;

C. notify Employees eligible to participate in the Plan of:

    1. the Plan's availability and terms,

    2. the premium payment benefits available for election,

    3. the maximum annual Salary Reduction Contribution and/or Salary Deduction Contribution amounts for each available premium payment benefit, and

    4. the procedures for enrolling and making and changing elections;

D. supply eligible Employees with any forms and agreements they must complete;

E. prepare and file all annual reports or returns, plan descriptions, financial statements, and other documents required by law or under the Plan's terms; and

F. record its and the Employer's acts and determinations regarding the Plan and preserve these records in its custody.

10.3 Plan Administrator's Powers

Except as expressly limited or reserved in the Plan to the Company, the Board of Directors, or an Employer, the Plan Administrator shall have the right to exercise, in a uniform and nondiscriminatory manner, full discretion with respect to the administration, operation, and interpretation of the Plan. Without limiting the generality of the foregoing rights, the Plan Administrator shall have full power and discretionary authority to:

A. require any person to furnish such information as the Plan Administrator may request from time to time and as often as the Plan Administrator determines reasonably necessary for the purpose of proper administration of the Plan and as a condition to the individual's receiving benefits under the Plan;

B. make and enforce such rules and prescribe the use of such forms as the Plan Administrator determines reasonably necessary for the proper administration of the Plan;

C. interpret the Plan and decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions;

D. determine all questions concerning the eligibility of any individual to participate in, be covered by, and receive benefits under the Plan pursuant to the provisions of the Plan;

E. determine whether objective criteria set forth in the Plan have been satisfied respecting any term, condition, limitation, exclusion, and restriction or waiver thereof;

F. determine the amount of benefits payable, if any, to any person or entity in accordance with the provisions of the Plan; to inform the Employer or any other third party, as appropriate, of the amount of such benefits; to make claims decisions under the terms of the Plan; and to provide a full and fair review to any individual whose claim for benefits has been denied in whole or in part;

G. delegate to other person(s) any duty that otherwise would be a fiduciary responsibility of the Plan Administrator under the terms of the Plan;

H. engage the services of such person(s) and entity or entities as it deems reasonably necessary or appropriate in connection with the administration of the Plan;

I. make such administrative or technical amendments to the Plan as may be reasonably necessary or appropriate to carry out the intent of the Employer, including such amendments as may be required or appropriate to satisfy the requirements of the Code and ERISA and the rules and regulations from time to time in effect under any such laws, or to conform the Plan with other governmental regulations or policies; and

J. pay all reasonable and appropriate expenses incurred in connection with the management and administration of the Plan including, but not limited to, premiums or other considerations payable under the Plan and fees and expenses of any actuary, accountant, legal counsel, or other specialist engaged by the Plan Administrator.

10.4 Finality of Decisions

The Plan Administrator shall have full power, authority and discretion to enforce, construe, interpret and administer the Plan. All decisions and determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on Covered Persons and all other interested parties.

10.5 Compensation and Bonding of Plan Administrator

Unless otherwise agreed to by the Company, the Plan Administrator shall serve without compensation for services as such, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid as specified in Section 12.17. Unless otherwise determined by the Company or unless required by federal or state law, the Plan Administrator shall not be required to furnish bond or other security in any jurisdiction.

10.6 Liability Insurance

The Company may obtain liability coverage at the Company’s expense to insure any Employee serving as Plan Administrator against legal liability that may arise from being the Plan Administrator or performing the Plan Administrator's duties.

10.7 Reserved Powers

The Company reserves the powers, among others:

A. to adopt the Plan;

B. to amend, terminate, or merge the Plan according to Article XI; and

C. to appoint and remove any Claim Administrator or Plan Administrator.

ARTICLE XI

AMENDMENT, TERMINATION OR MERGER OF PLAN

11.1 Right to Amend the Plan

Except as provided in Section 11.3, the Company reserves the unlimited right to amend the Plan in any way. Any amendment to the Plan shall be in writing and shall be adopted by the Board of Directors in accordance with its normal procedures, except that the Plan Administrator shall have the authority to amend the Plan to comply with applicable law or regulations, or to comply with the Company's intent.

11.2 Right to Terminate or Merge the Plan

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely, Board of Directors (or its duly authorized representative) reserves the unlimited right to terminate or merge the Plan. Any termination or merger of the Plan shall be in writing and shall be adopted by the duly authorized representative of the Company acting in accordance with its regular duties for the Company.

11.3 Effect of Amendment, Termination or Merger

Any amendment, termination or merger of the Plan shall be effective at such date as the Company shall determine except that no amendment, termination or merger may be retroactive unless remedial to comply with a law or regulatory requirement the Company or the Plan is subject to.

ARTICLE XII

MISCELLANEOUS

12.1 No Employment Rights

The Plan is a voluntary undertaking of the Employer and does not constitute a contract with any person. The Plan is not an inducement or condition of an Employee's employment with any Employer. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any Employee or any other person, any legal or equitable rights against his or her Employer, the Company or their shareholders, directors, officers, employees or agents, or as giving any person the right to be retained in the employ of the Employer.

12.2 Exclusive Rights

No individual shall have a right to benefits under the Plan except as specified herein; and in no event shall any right to benefits under the Plan be or become vested. This Plan is not a guarantee of continuation of any benefits or coverage offered through the Plan.

12.3 No Property Rights

No one has any right, title, or interest in the property of the Company or the Employer by virtue of the Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to him or her.

12.4 No Assignment of Benefits

Except as provided in Section 9.12, benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void. Notwithstanding the foregoing, a Covered Person may direct, in writing, that benefits payable to him or her be paid instead to an institution in which he or she is or was hospitalized, to a provider of medical or dental services or supplies furnished or to be furnished to him or her, or to a person or entity that has provided or paid for, or agreed to provide or pay for, any benefits payable under the Plan. The Plan reserves the right to make payment directly to the Covered Person. No payment by the Plan pursuant to such direction and assignment shall be considered as recognition by the Plan of a duty or obligation to pay a provider of medical or dental services or supplies except to the extent the Plan actually chooses to do so.

12.5 Right to Offset Future Payments

In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Plan to recover an erroneous or excess payment in any other manner.

12.6 Right to Recover Payments

Whenever a payment has been made by the Plan, including erroneous payments, in a total amount in excess of the amount payable under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from the person to or for whom the payment was made.

12.7 Misrepresentation or Fraud

A Covered Person who receives benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator shall decide such matters on a case by case basis.

12.8 Legal Action

Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan must first exhaust the Plan's claim, review, and appeal procedures. Unless otherwise provided by law, the Company and the Plan Administrator are the only necessary parties to any action or proceeding that involves the Plan or its administration. No Employee, Employer, or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

No action at law or in equity in any court or agency shall be brought to recover benefits under the Plan prior to the exhaustion of the claims and appeals procedures set forth in Article IX, nor shall an action be brought at all unless within 12 months from the date the cause of action accrued. A cause of action shall be deemed to have accrued on the earlier of the following: (i) when the Covered Person Beneficiary or claimant has exhausted his administrative remedies under the Plan; (ii) when the Plan Administrator fails to produce documents in the time or manner required by ERISA in response to the Covered Person’s, Beneficiary’s or claimant’s written request; (iii) when the claimant first was advised that he or she was an independent contractor; or (iv) when the Covered Person, Beneficiary or claimant first knew or should have known of the action allegedly violating 29 U.S.C. § 1140. Failure to bring an action in court within this time frame shall preclude a Covered Person, Beneficiary or claimant from bringing any action in court.

12.9 Governing Law

The provisions of the Plan shall be administered, and all questions pertaining to the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable and, to the extent not preempted, the laws of the State of Alabama.

12.10 Governing Instrument

This document, together with any documentation incorporated by reference herein, is the legal instrument governing the Plan. In case of conflict between this document and any other writing or evidence, the terms of this document shall govern.

12.11 Savings Clause

If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

12.12 Captions and Headings

The captions and headings of an Article, Section or provision of the Plan are for convenience and reference only and are not to be considered in interpreting the terms and conditions of the Plan.

12.13 Notices

No notice or communication in connection with the Plan made by a claimant or an Employee shall be effective unless duly executed on a form provided or approved by, and filed with, the appropriate Plan Administrator (or his or her representative).

12.14 Waiver

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in a writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and only for the stated period, and such waiver shall operate only as to the specific term, condition, or provision waived.

12.15 Parties' Reliance

The Company, the Board of Directors, the Employer, the Plan Administrator and anyone to whom the Plan's operation or administration is delegated may rely conclusively on any advice, opinion, valuation, or other information furnished by any actuary, accountant, appraiser, legal counsel, or physician the Plan engages or employs. A good faith action or omission based on this reliance is binding on all parties, and no liability can be incurred for it except as the law requires. No liability shall be incurred for any other action or omission of the Board of Directors, the Company, the Employer or their employees, except for willful misconduct or willful breach of duty to the Plan.

12.16 Disclaimer

The Company makes no assertion or warranty about:

A. whether Plan benefits are or will be excludable from a Covered Employee's gross income for federal or state income tax purposes, or

B. whether any other tax treatment is or will be applicable.

12.17 Expenses

All expenses of the Plan shall be paid from forfeitures, Employee contributions, or by the Plan, unless otherwise paid by the Employer. The Employer may advance expenses to the Plan, subject to reimbursement, without obligating itself to pay such expenses.

12.18 Indemnification

The Employer, to the extent permitted by law, shall indemnify and hold harmless the Board of Directors, any employee or officer or shareholder of the Company or the Employer from and against all loss, damages, liability and reasonable costs and expenses incurred in carrying out his or her responsibilities under the Plan, unless due to the bad faith or willful misconduct of such person, provided that such individual's attorney's fees and any amount paid in settlement shall be approved by the Company.

12.19 Employees' Tax Obligations

A. Excludability Determination

Covered Employees themselves must determine whether Plan benefits are excludable for tax purposes, and must notify the Plan Administrator if they have reason to believe a payment is not excludable.

B. Liability and Payment

If the Plan Administrator determines at any time after a Plan Year's end that Employees' Salary Reduction Contributions or Salary Deduction Contributions or other Employer contributions exceeded limits allowed by law for any reason including, but not limited to, erroneous information, administrative error, or a final determination that the Plan does not qualify as a cafeteria plan under Code section 125 for the Plan Year, then Covered Employees must:

1. pay any local, state, and federal income taxes and related penalties and interest due with respect to the excess Salary Reduction Contributions or other Employer contributions, and

2. reimburse the Employer for the Employee's share of any local, state, and federal tax contributions the Employer would have withheld or other applicable deductions the Employer would have taken had the excess Salary

Reduction Contributions or other Employer contributions been treated as taxable income.

ARTICLE XIII

HIPAA PRIVACY AND SECURITY

13.1 Scope

The provisions of this Article XIII shall apply to the medical, dental, employee assistance benefits and health care spending account benefits.

13.2 Definitions

For purposes of this Article XIII, the following terms have the following meanings:

A. “Business Associate” means a person or entity that performs a function or activity regulated by HIPAA on behalf of the group health plans provided under the Plan and involving individually identifiable health information. Examples of such functions or activities are claims processing, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation and financial services. A Business Associate may be a Covered Entity. However, Insurers and HMOs are not Business Associates of the plans they insure. Effective February 17, 2010, a person or entity that transmits PHI to a covered entity (or its business associate) and routinely requires access to that PHI may also be a business associate. Examples of such entities include health information exchange organizations, regional health information organizations and e-prescribing gateways. Vendors that contract with covered entities offering certain personal health records to individuals may also be considered business associates.

B. “Covered Entity” means a group health plan (including an employer plan, Insurer, HMO and government coverage such as Medicare); a health care provider (such as a doctor, hospital or pharmacy) that electronically transmits any health information in connection with a transaction for which the U.S. Department of Health and Human Services has established an electronic data interchange standard; and a health care clearinghouse (an entity that translates electronic information between nonstandard and HIPAA standard transactions).

C. “Protected Health Information or PHI” means individually identifiable health information created or received by a Covered Entity. Information is “individually identifiable” if it names the individual person or there is a reasonable basis to believe components of the information could be used to identify the individual. “Health Information” means information, including genetic information, whether oral or recorded in any form or medium, that (i) is created by a health care provider, health care plan, employer, life insurer, public health authority, health care clearinghouse, or school or university; and (ii) relates to the past, present, or future physical or mental health or condition of a person, the provision of health care to a person; or the past, present or future payment for health care.

13.3 Uses and Disclosures of PHI

The Plan and the Employer may disclose a Covered Employee's PHI or ePHI to the Employer (or to the agent of the Employer) for the plan administration functions under 45 CFR 164.504(a), to the extent not inconsistent with the HIPAA regulations. The Plan will not disclose PHI or ePHI to the Employer except upon receipt of a certification by the Employer that the Plan incorporates the agreements of Sections 13.4 and 13.5, except as otherwise permitted or required by law.

13.4 Privacy Agreements of the Employer

As a condition for obtaining PHI from the Plan and its Business Associates the Employer agrees it will:

A. Not use or further disclose such PHI other than as permitted by Section 13.3, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;

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

C. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

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

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

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

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

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

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

1. Employees With Access to PHI: The employees, classes of former employees or other individuals under the control of the Employer listed on Appendix E are the only individuals that may access PHI received from the Plan.

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

3. Mechanism for Resolving Noncompliance: If the Employer or the persons listed on Appendix E determine that any person described in (1), above, has violated any of the restrictions of this Article XIII, then such individual shall be disciplined in accordance with the policies of the Employer established for purposes of privacy and security compliance, up to and including dismissal from employment. The Employer shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

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

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

2. the circumstances surrounding the Breach;

3. the date of the Breach and the date of its discovery;

4. the information Breached;

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

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

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

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

Notwithstanding the foregoing, the terms of this Article XIII shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made

pursuant to 45 CFR 164.504(f)(1)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations.

13.5 Security Agreements of the Employer

As a condition of obtaining e-PHI from the Plan, its Business Associates, Insurers and HMOs, the Employer agrees it will:

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

B. Ensure that the adequate separation between the Plan and the Employer as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

C. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;

D. Report to the Plan any security incident of which it becomes aware. For purposes of this Amendment, security incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI; and

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

APPENDIX A

AUSTAL USA, LLC

DEPENDENT CARE SPENDING ACCOUNT PLAN

ARTICLE I

PLAN ESTABLISHMENT

1.1 Effective Date

The Austal USA, LLC Dependent Care Spending Account Plan ("the Plan") is amended and restated effective January 1, 2012.

1.2 Purpose

The Plan is created exclusively for Employees, as defined in Section 2.13 of the Cafeteria Plan. The Plan's purpose is to reimburse Covered Employees, as defined in Section 2.1 of this Plan, for Dependent Care Expenses, as defined in Section 2.2 of this Plan.

1.3 Qualification

The Plan is intended to qualify as a dependent care assistance program under section 129 of the Internal Revenue Code of 1986, as amended (the "Code"). The Plan's reimbursements of Dependent Care Expenses are intended to be eligible for exclusion from Covered Employees' gross income under Code section 129(a). This document is intended to satisfy the written plan document requirement of Code section 129(d)(1).

1.4 Incorporation By Reference

The term Cafeteria Plan as used in this Plan means the Austal USA, LLC Cafeteria Plan as defined in Section 1.3 of the Austal USA, LLC Group Health and Welfare Benefit Plan. The terms of the Cafeteria Plan are incorporated by reference wherever they apply to this Plan's operation to the extent such provisions do not conflict with the terms of this Plan.

1.5 Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Company, defined in Section 2.7 of the Cafeteria Plan, in its sole discretion and in accordance with the provisions of Article XI of the Cafeteria Plan may amend or terminate the Plan or any provision of the Plan.

ARTICLE II

DEFINITIONS

When capitalized in this document, these words and phrases have the following meanings:

2.1 Covered Employee

Covered Employee means an Employee who satisfies the participation requirements of Article III.

2.2 Dependent Care Expenses

Dependent Care Expenses means expenditures for dependent care as described in Section 4.4.

2.3 Dependent Care Spending Account Plan

Dependent Care Spending Account Plan means the notational account established on behalf of each Covered Employee who elects the dependent care spending account premium payment benefit under the Cafeteria Plan to which the Covered Employee allocates Salary Reduction Contributions for the reimbursement of Dependent Care Expenses.

2.4 Effective Date

Effective Date means the date the amended and restated Plan becomes operative; the Effective Date is January 1, 2012.

2.5 Exclusions

Exclusions means the exclusions in Article V.

2.6 Maximum Annual Benefit

Maximum Annual Benefit means the total Salary Reduction Contributions a Covered Employee authorizes to his or her Dependent Care Spending Account, according to the election requirements of Section 6.1, for Dependent Care Expense reimbursement, which amount must be not more than $5,000, except as otherwise limited under Section 4.5(B).

2.7 Plan

Plan means the Austal USA, LLC Dependent Care Spending Account Plan as herein set forth and as amended from time to time.

2.8 Plan Year

Plan year means the 12 month period beginning January 1 and ending December 31.

2.9 Qualifying Individual

Qualifying Individual means:

A. a Dependent, as defined in Section 2.11 of the Cafeteria Plan who is either:

1. under age 13 and claimable as a personal exemption deduction under Code section 152(a)(1) on the Covered Employee's federal income tax return, or

2. *physically or mentally incapable of caring for him or herself* and is a qualifying relative under Section 152 of the Code (without regard to subsections (b)(1), (b)(2) and (d)(1)(B)) and who resides with the Employee for more than half of the year; or

B. the Spouse of a Covered Employee who is *physically or mentally incapable of caring for him or herself*, and who resides with the Employee for more than half of the year.

Physically or mentally incapable of caring for him or herself means:

C. incapable of caring for one's own hygienic or nutritional needs, or

D. requiring another person's full-time attention for one's own safety or the safety of others.

Whether a person is *physically or mentally incapable of caring for him or herself* is determined on a daily basis.

ARTICLE III

PARTICIPATION

3.1 Participation

An Employee is a Covered Employee and participates in the Plan during those periods in which the Employee:

A. participates in the Cafeteria Plan, and

B. has allocated an amount to his or her Dependent Care Spending Account.

Except for Dependent Care Expenses incurred before Plan coverage ceases and subject to satisfying the procedural requirements of Article VI, no Plan benefits are payable after coverage terminates.

3.2 Termination of Participation

A Covered Employee shall cease to participate in the Plan when he or she is no longer a participant in the Cafeteria Plan, when the Covered Employee revokes his or her election to participate in the Plan, or when the Covered Employee terminates employment, retires or dies.

ARTICLE IV

DEPENDENT CARE REIMBURSEMENT

BENEFIT

4.1 Right to Benefit

Subject to the following terms and limits and the Exclusions, Covered Employees are entitled to reimbursement for Dependent Care Expenses.

4.2 Maintenance of Accounts

The Plan Administrator shall maintain a Dependent Care Spending Account for each Employee who elects the dependent care spending account premium payment benefit. The dependent care spending account premium payment benefit that the Employee elected under the Cafeteria Plan shall be credited to the Employee's Dependent Care Spending Account on a pro-rata basis over the period for which the Employee's election is effective.

4.3 Amount Payable

Subject to the procedural requirements of Article VI, payable Dependent Care Expenses may not exceed the dependent care spending account premium payment benefit the Covered Employee authorized and which was credited in accordance with Section 4.2, less any payments previously made during the Plan Year — up to the Maximum Annual Benefit.

If any balance remains in the a Covered Employee’s Dependent Care Spending Account at the end of the Plan Year after all reimbursements have been made, such balance shall not be carried over to reimburse the Covered Employee for Dependent Care Expenses incurred during a subsequent Plan Year nor returned to the Covered Employee and the Covered Employee shall forfeit all rights with respect to such balance. Any amounts forfeited under this Section 4.3 shall not be segregated or invested in an interest bearing account, but shall remain the property of the Employer to be used to pay administrative expenses, to cover expense losses, or used in any other manner as the Employer in its discretion, exercised in a uniform and nondiscriminatory manner, directs.

4.4 Dependent Care Expenses

Dependent Care Expenses means *employment-related* expenses that a Covered Employee *incurs* — while employed — for:

A. *Household services*, and

B. *Care* of a Qualifying Individual.

Employment-related, as defined in Code section 21(b), means incurred to enable a Covered Employee to be gainfully employed. In the case of a married Covered Employee, to be employment-related, the expense must also enable the Covered Employee's Spouse to: be gainfully employed, actively seek gainful employment, or be a *full-time student,* unless the Spouse is described in Section 2.9(B).

Incurs refers to the date services resulting in employment-related expenses are provided — not the date charged, billed, or paid.

Household services means services ordinarily necessary to maintain a Covered Employee's home and rendered as part of a Qualifying Individual's *care*.

Care means services primarily to assure the well-being and protection of at least one Qualifying Individual.

Full-time student means a person enrolled at and attending an educational institution during at least part of each of five calendar months of the Covered Employee's tax year for the number of course hours that the institution considers to be a full-time course of study.

4.5 Limits

A. On What the Plan Pays

1. For Care Furnished Outside Covered Employee's Household

   Dependent Care Expenses for care provided outside a Covered Employee's home or in a *Qualified Dependent Care Center* is reimbursed only if such care is furnished for a Qualifying Individual:

   a. described in Section 2.9(A)(1), or

   b. described in Section 2.9(A)(2) or (B) who regularly spends at least 8 hours each day in the Covered Employee's home.

   Qualified Dependent Care Center means a facility:

   a. in compliance with all applicable state and local laws and regulations, and

   b. providing care for more than 6 persons (other than facility residents) on a regular, compensation-for-service basis.

2. To Certain "Highly Compensated" Employees

   Benefits payable under the Plan to each highly compensated employee, as defined in Code section 414(q), are limited to the extent necessary to avoid violating Code section 129(d)(8).

B. On Exclusion from Gross Income

1. Individual Exclusion Limit

Plan reimbursement for Dependent Care Expenses is excludable from a Covered Employee's gross income only to the extent the Dependent Care Expense does not exceed:

a. the sum of the Covered Employee's actual salary reductions for the Plan Year,

or, if less,

b. the Maximum Annual Benefit.

2. Gross Income Exclusion Limit

The amount of dependent care expenses reimbursed during a Covered Employee's taxable year by all plans, including the Plan, that qualify as dependent care plans under Code section 129 may not exceed:

a. $5,000 (or $2,500 for a married Covered Employee filing a separate federal income tax return),

or, if less,

b. the Covered Employee's *earned income* (or if less, the Covered Employee's Spouse's *earned income*, if the Covered Employee was married at the end of his or her tax year).

Earned income means wages, salaries, tips, and other compensation, to the extent such amounts are includible in taxable income for the year, like strike benefits, disability pay reported as wages, and net earnings from self-employment.

Earned income does not include pensions, annuities, social security payments, workers' compensation, unemployment compensation, or a nonresident alien's income not connected with United States business.

Earned income is computed without considering community property laws.

Earned income of a Spouse who is a full-time student, as defined in Section 4.4, or who is *physically or mentally incapable of caring for him or herself*, as defined in Section 2.8, is deemed to be not less than $250 per month for Covered Employees with one Qualifying

Individual or $500 per month for Covered Employees with two or more Qualifying Individuals.

3. Reporting Identifying Information Limit

Plan reimbursement for Dependent Care Expenses is excludable from a Covered Employee's gross income only if the Covered Employee reports on the federal income tax return to which the exclusion relates, the name, address, and taxpayer identification number (or other information acceptable to comply with federal reporting requirements) of each dependent care service provider furnishing dependent care services to the Covered Employee during the year.

ARTICLE V

EXCLUSIONS

5.1 General Rules

A. The Plan pays only those Dependent Care Expenses incurred by an Employee:

1. during the current Plan Year, except that, the Plan allows a grace period of two and one half months following the end of the Plan Year in which Covered Employees may incur Dependent Care Expenses for reimbursement from amounts remaining unused at the end of the immediately preceding Plan Year. This reimbursement will be treated as if the expenses had been incurred in the prior year,

2. while the Employee is a Covered Employee, and

3. to allow the Covered Employee (and Spouse, if married) to continue gainful employment (or, if married and the Spouse is unemployed, to allow the Covered Employee's Spouse to actively seek gainful employment or be a full-time student, as defined in Section 4.4, unless the Spouse is described in Section 2.9(B) of the Plan).

B. Except as provided in Section 5.1(A)(3), the Plan does not reimburse amounts paid for Dependent Care Expenses incurred while a Covered Employee (or Spouse, if married) is off work for any reason, including illness or vacation. However, if Dependent Care Expenses are paid to the dependent care services provider on a weekly or longer basis, Dependent Care Expenses incurred during a temporary absence from work for illness or vacation will not be subject to this exclusion.

5.2 Specific Exclusions

The Plan does not reimburse amounts paid in connection with:

A. a Qualifying Individual's overnight camp;

B. services rendered by:

1. a Covered Employee's (and if married, the Covered Employee's Spouse's) child (within the meaning of Code section 152(c)(3)) under age 19 at the Plan Year's end,

2. a Covered Employee’s Spouse or parent of the Covered Employee’s child, or

3. a person for whom the Covered Employee (or if married, the Covered Employee's Spouse) is entitled to a federal income tax deduction under Code section 151(c) for the Covered Employee's tax year.

5.3 Conditional Exclusions

Unless incidental, minimal, and inseparable from the cost of caring for a Qualifying Individual, the Plan shall not pay any charges in connection with a Qualifying Individual's:

A. food,

B. clothing,

C. entertainment,

D. education (kindergarten and above), or

E. transportation between the Covered Employee's home and the place where dependent care is provided unless such transportation is furnished by the dependent care provider.

ARTICLE VI

PROCEDURES

6.1 Enrollment and Election Procedures

Employees may enroll and make elections only by filing the appropriate, completed forms with the Plan Administrator within prescribed time limits. Rules and deadlines for enrolling and making or changing elections are stated in the Cafeteria Plan.

6.2 Claim Procedures

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services received, is received by the Claim Administrator by March 15 following the Plan Year to which the claim relates.

6.3 Claim Administrator

The Plan Administrator and/or the Company shall have the authority to appoint, remove, and replace one or more Claim Administrators. A Claim Administrator shall have the duties, powers, and responsibilities set forth herein. In the absence of such an appointment and except as hereinafter provided, the Plan Administrator shall also be the Claim Administrator.

6.4 Claims Administration

The Claim Administrator shall have the duty to receive and review claims for benefits under the Plan, to determine what amount, if any, is due and payable under the terms and conditions of the Plan, and to make appropriate disbursements of benefit payments to persons entitled thereto.

6.5 Proof of Claim

As a condition of receiving Plan benefits, claimants must:

A. submit to the Plan Administrator:

   1. a properly completed and timely filed claim form,
   2. a written declaration stating the dependent care expense has not been reimbursed and is not reimbursable under any other dependent care plan, and
   3. a written declaration from an independent third party stating the Covered Employee has incurred the dependent care expense and the amount of such expense; and

B. prove any claimed status.

Page intentionally left blank

APPENDIX B

AUSTAL USA, LLC

HEALTH CARE SPENDING ACCOUNT PLAN

ARTICLE I

PLAN ESTABLISHMENT

1.1 Effective Date

The Austal USA, LLC Health Care Spending Account Plan ("the Plan") is amended and restated effective January 1, 2012.

1.2 Purpose

The Plan is created exclusively for Employees, as defined in Section 2.13 of the Cafeteria Plan. The Plan's purpose is to reimburse Covered Employees, as defined in Section 2.1 of this Plan, for Qualifying Medical Expenses, as defined in Section 2.9 of this Plan.

1.3 Qualification

A. ERISA

The Plan is an *employee welfare benefit plan*, as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This document is intended to satisfy the written plan document requirement of ERISA section 402.

B. Internal Revenue Code

The Plan is intended to qualify as a health plan under section 105(e) of the Internal Revenue Code of 1986, as amended ("the Code"). The Plan's Qualifying Medical Expense reimbursements are intended to be eligible for exclusion from Covered Employees' gross income under Code section 105(b). This document is intended to satisfy the written plan document requirement of Treasury regulations section 1.105-11(b)(1)(i).

1.4 Incorporation By Reference

The term Cafeteria Plan as used in this Plan means The Austal USA, LLC Cafeteria Plan as referenced in Section 1.3 of the Austal USA, LLC Group Health and Welfare Benefits Plan. The terms of the Cafeteria Plan are incorporated by reference wherever they apply to this Plan's operation, to the extent such provisions do not conflict with the provisions of this Plan.

1.5 Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Company, as defined in Section 2.7 of the Cafeteria Plan, in its sole discretion and in accordance with the provisions of Article XI of the Cafeteria Plan may amend or terminate the Plan or any provision of the Plan.

ARTICLE II

DEFINITIONS

When capitalized in this document, these words and phrases have the following meanings:

2.1 Covered Employee

Covered Employee means an Employee who satisfies the participation requirements of Article III.

2.2 Dependent

Dependent means a Covered Employee's:

A. Spouse, and

B. dependent(s) as defined in Code section 152, (without regard to (b)(1), (b)(2), and (d)(1)(B)), and

C. the Covered Employee’s child as defined in Code section 152(f)(1)) who has not attained age 27 as of the end of the taxable year.

2.3 Effective Date

Effective Date means the date the amended and restated Plan becomes operative; the Effective Date is July 1, 2020.

2.4 Exclusions

Exclusions means the exclusions in Article V.

2.5 Health Care Spending Account

Health Care Spending Account means the notational account established on behalf of each Covered Employee who elects the Health Care Spending Account premium payment benefit under the Cafeteria Plan to which the Covered Employee allocates Salary Reduction Contributions for the reimbursement of Qualifying Medical Expenses.

2.6 Maximum Annual Benefit

Maximum Annual Benefit means the total Salary Reduction Contributions a Covered Employee authorizes to his or her Health Care Spending Account, according to the election procedures of Section 6.1, for Qualifying Medical Expense reimbursement, which amount must be not more than $2,750, or if less, the maximum allowed under Section 125 of the Code.

2.7 Plan

Plan means the Austal USA, LLC Health Care Spending Account Plan as herein set forth and as amended from time to time.

2.8 Plan Year

Plan Year means the 12 month period beginning January 1 and ending December 31.

2.9 Qualifying Medical Expenses

Qualifying Medical Expenses means a Covered Employee's and a Dependent's expenses *incurred* during the Plan Year for medical care, as defined in Code section 213(d)(1)(A) and (B). However, the Plan allows a grace period of two and one half months following the end of the Plan Year in which Covered Employees and Dependents may incur Qualifying Medical Expenses to be reimbursed under the current Plan Year's election. To be a Qualifying Medical Expense, the medical care must be essential to diagnose, cure, mitigate, treat, or prevent a disease or disorder or to affect an unsound structure or function of the mind or body. *Incurred* refers to the date the medical care is provided — not to the date charged, billed, or paid. Notwithstanding the foregoing, "medicine and drugs" within the meaning of Treasury Regulations Section 1.213-1(e)(2) shall not be an eligible medical expense unless the medicine or drug is prescribed by a qualified provider (regardless of whether the medicine or drug is available without a prescription) or is insulin.

ARTICLE III

PARTICIPATION

3.1 Participation

An Employee is a Covered Employee and participates in the Plan during those periods in which the Employee:

A. participates in the Cafeteria Plan, and

B. has allocated an amount to his or her Health Care Spending Account.

Except for Qualifying Medical Expenses incurred before Plan coverage ceases and subject to satisfying the procedural requirements of Article VI, no Plan benefits are payable after coverage terminates.

3.2 Termination of Participation

A Covered Employee shall cease to participate in the Plan when he or she is no longer eligible to participate in the Cafeteria Plan, when the Covered Employee revokes his or her election to participate in the Plan, or when the Covered Employee terminates employment, retires or dies.

Notwithstanding Section 3.1, a Covered Employee ordered or called to active military duty (by reason of being a member of a reserve component as defined in section 101 of title 37, United States Code) for a period in excess of 179 days, or for an indefinite period of time, may elect take his or her unused Health Care Spending Account balance as a cash distribution by the last day of the Plan Year, extended for the 2-1/2 month grace period. Such distribution shall be subject to income tax and the Covered Employee shall cease to participate in the Plan for the remainder of the Plan Year. The distribution amount shall be calculated as the amount contributed to date for the Plan Year minus the amount previously reimbursed for the Plan Year.

ARTICLE IV

MEDICAL EXPENSE BENEFIT

4.1 Right to Benefit

Subject to the following terms and limits and the Exclusions, Covered Employees are entitled to reimbursement for Qualifying Medical Expenses.

4.2 Maintenance of Accounts

The Plan Administrator shall maintain a Health Care Spending Account for each Employee who elects the health care spending account premium payment benefit. The health care spending account premium payment benefit elected by the Employee shall be credited to his or her Health Care Spending Account as of the first day that the Employee's election is effective.

4.3 Amount Payable

Subject to the procedural requirements of Article VI, payable Qualifying Medical Expenses may not exceed the health care spending account premium payment benefit the Covered Employee elected to be credited to his or her Health Care Spending Account for the Plan Year, less any payments previously made during the Plan Year — up to the Maximum Annual Benefit.

4.4 Qualifying Medical Expenses

Qualifying Medical Expenses, as defined in Section 2.9, that are not covered by any other health plan include, for example, expenses for:

A. acupuncture

B. ambulance service

C. birth control pills

D. breast pumps and supplies that assist lactation

E. capital expenses for home improvements and special equipment installed in the car or home, if the main reason for the improvement or equipment is for medical care, but only to the extent the expenditure exceeds any increase in the improved property's value

F. Christian Science practitioners

G. crutches

H. dental treatment

I. doctor's fees including, but not limited to: anesthesiologists, gynecologists, chiropodists, chiropractors, dermatologists, neurologists, obstetricians, ophthalmologists, osteopaths, podiatrists, pediatricians, psychiatrists, and psychologists

J. eye examinations, eyeglasses, and contact lenses

K. hearing examinations and hearing aids

L. hospital services

M. laboratory fees and diagnostic testing

N. mental health treatment

O. nursing home services, including meals and lodging

P. nursing services

Q. organ transplant expenses

R. oxygen and oxygen equipment

S. prescription drugs

T. prostheses

U. smoking cessation products

V. special schooling and equipment for the mentally or physically handicapped

W. sterilization

X. substance abuse treatment

Y. surgery

Z. therapy

AA. transportation for medical reasons

BB. wheelchairs

CC. X-ray fees

4.5 Limits

The Plan reimburses Qualifying Medical Expenses only to the extent the charge is not compensated for by any prepaid health coverage, group health plan, medical insurance, or

otherwise. Qualifying Medical Expenses include deductibles and co-payments if not reimbursed through coordination of benefits with a secondary payor.

ARTICLE V

EXCLUSIONS

5.1 General Rules

A. The Plan pays only those Qualifying Medical Expenses incurred by an Employee or the Employee's Dependent:

1. during the current Plan Year, except that, the Plan will allow a grace period of two and one half months following the end of the Plan Year in which Covered Employees may incur Qualifying Medical Expenses for reimbursement from amounts remaining unused at the end of the immediately preceding Plan Year. This reimbursement will be treated as if the expenses had been incurred in the prior year,

2. while the Employee is a Covered Employee.

B. The Plan does not reimburse amounts paid for services or supplies that merely improve health or morale generally.

5.2 Specific Exclusions

The Plan does not reimburse amounts paid in connection with:

A. cosmetic surgery or similar procedure unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease,

B. custodial or domiciliary care,

C. diaper service,

D. funeral and burial expenses,

E. health club membership fees and dues,

F. household and domestic help,

G. illegal services and supplies,

H. insurance premiums of any kind including those for health maintenance organizations, life insurance, long term care, loss of earnings, accidental death or dismemberment, automobile insurance, and group medical or other health insurance,

I. meals and lodging at a nonmedical facility,

J. maternity clothes or uniforms,

K. nursing services for a normal, healthy newborn baby, except for breast pumps and supplies that assist lactation,

L. over-the-counter or nonprescription drugs or items unless specifically permitted under applicable law or regulation,

M. personal use items like cosmetics, toiletries, and items for personal hygiene or beautification,

N. schooling or tuition for scholastic improvement or discipline,

O. social activities like dancing or swimming lessons,

P. special foods or dietary supplements like vitamins, minerals, bottled water, and diet foods,

Q. transportation for nonmedical reasons,

R. trips or vacations, and

S. long term care expenses.

ARTICLE VI

PROCEDURES

6.1 Enrollment and Election Procedures

Employees may enroll and make elections only by filing the appropriate, completed forms with the Plan Administrator within prescribed time limits. Rules and deadlines for enrolling and making or changing elections are stated in the Cafeteria Plan.

6.2 Claim Procedures

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services received, is received by the Claim Administrator by March 15 following the Plan Year to which the claim relates.

6.3 Claim Administrator

The Plan Administrator and/or the Company shall have the authority to appoint, remove, and replace one or more Claim Administrators. A Claim Administrator shall have the duties, powers, and responsibilities set forth herein. In the absence of such an appointment and except as hereinafter provided, the Plan Administrator shall also be the Claim Administrator.

6.4 Claims Administration

The Claim Administrator shall have the duty to receive and review claims for benefits under the Plan, to determine what amount, if any, is due and payable under the terms and conditions of the Plan, and to make appropriate disbursements of benefit payments to persons entitled thereto.

6.5 Proof of Claim

As a condition of receiving Plan benefits, claimants must:

A. submit to the Plan Administrator:

   1. a properly completed and timely filed claim form,

   2. a written declaration stating the Qualifying Medical Expense has not been reimbursed and is not reimbursable under any other health plan, and

   3. a written declaration from an independent third party stating the Covered Employee has incurred the medical expense and the amount of such expense; and

B. prove any claimed status.

Page intentionally left blank

APPENDIX C

HEALTH REIMBURSEMENT ARRANGEMENT

ARTICLE I
HEALTH REIMBURSEMENT ARRANGEMENT

1.1 Participation

Each eligible Participant who elects to participate in the medical/prescription drug coverage option (the "HRA-Related Medical Plan") designated by the Participating Employer as offered in conjunction with the Health Reimbursement Arrangement ("HRA") is entitled to receive cash reimbursement from the Participating Employer for certain health-related expenses (described below) incurred during a coverage period in an amount not to exceed the amount credited to the Participant's HRA account. An eligible Participant will receive credits to his or her HRA account at such times and in such amounts as described below.

1.2 General Rules

The HRA is intended to qualify as an employer-provided health reimbursement arrangement, as described in IRS Notice 2002-45. Notwithstanding anything in the Plan to the contrary, the HRA is not intended to be a Code §125 "cafeteria plan", and any reimbursements paid under the HRA are provided solely by the Employer and not pursuant to any salary reduction election. Any provision of this Plan (or of any other document that controls the terms of the HRA) that would cause the HRA to fail to qualify as an employer-provided health reimbursement arrangement described in IRS Notice 2002-45 or that would cause the HRA to violate any applicable nondiscrimination requirements or other applicable legal requirements, will be ineffective.

1.3 Coverage Period

Coverage Period means the Plan Year.

1.4 Dependent

Dependent means any person who is a dependent of the Participant under Code §152 (as it applies for purposes of Code §105(b)).

1.5 Amounts Credited to HRA

The amount to be credited for each coverage period to the HRA account of each eligible Participant who has elected "employee only" medical coverage, "employee and family" medical coverage, "employee and child" medical coverage or "employee and spouse" medical coverage is set forth in the Applicable Documents identified in Appendix E.

The amount (as described above) to be credited to an eligible Participant's HRA account for a coverage period will be credited upon the Participant's enrollment in the HRA-

Related Medical Plan. In no event will amounts be available for reimbursement before they are credited to the Participant's HRA account.

1.6 Healthcare Related Expenses

Payments under the HRA will be made in cash as a reimbursement for health related expenses incurred during the coverage period and after the Participant's Participation Date by the Participant or his or her spouse or dependents that:

(i) Are not covered, paid or reimbursed under any other health plan coverage;

(ii) Meet the criteria for medical expenses under Code §213(d) (other than long term care expenses);

(iii) Are not taken as a deduction from income on the Participant's federal income tax return in any tax year; and

(iv) Meet any such criteria for coverage as the Administrator shall determine in its discretion in accordance with applicable law.

In no event will any Participant or former Participant have the right to receive cash or any other taxable or nontaxable benefit from the Account other than the reimbursement of medical care expenses, as defined in Code §213.

1.7 Expenses Covered Under Any Other Health Plan Coverage

Notwithstanding any other provision of the Plan (or other document which controls the terms of a Participant's health care flexible spending account or the HRA) that restricts a Participant from obtaining reimbursement from his or her health care flexible spending account or under the HRA for expenses that are covered, paid or reimbursed under any other health plan coverage, if, absent such restriction, an expense is reimbursable under both the health care flexible spending account and the HRA, the Participant may be reimbursed for such expense from the health care flexible spending account if the amount credited to the Participant's HRA account has been exhausted. In no event may a Participant receive reimbursement for the same expense from a health care flexible spending account and under the HRA.

1.8 Amounts credited as of the End of a Coverage Period

Amounts credited to a Participant's HRA account as of the end of a coverage period against which amount liabilities have not accrued during the coverage period may be carried forward to increase the maximum reimbursement amount in subsequent periods up to the limit described in the Applicable Documents that are identified in Appendix E, provided the Participant continues to elect coverage under the HRA-Related Medical Plan.

1.9 Requests for Reimbursement

Any Participant who wishes to receive a reimbursement from his or her HRA Account

must submit to the Administrator (or Insurer or designee of the Administrator, if applicable) a request for reimbursement on a form provided by the Administrator, along with such evidence as the Administrator (or Insurer or designee of the Administrator, if applicable) requires regarding the amount, nature and payment of such reimbursement. Such requests must be submitted by the ninetieth (90th) day following the end of the Plan Year.

1.10 Minimum Reimbursement Amounts

The Administrator (or Insurer or designee of the Administrator, if applicable) may establish reasonable rules regarding the minimum amount of eligible expenses that must be submitted for reimbursement to be made under the Plan.

1.11 Requests Exceeding Accrued HRA Account Balance

Requests from a Participant for reimbursement of eligible expenses that exceed the accrued balance in the Participant's HRA Account will be held in a suspense account until the Account has been credited with sufficient amounts to permit reimbursement.

1.12 Termination of Participation

Additionally, amounts credited to a Participant's HRA account as of the termination of the Participant's employment may be used for reimbursement only for eligible expenses which were incurred prior to the Participant's termination of employment. Any amounts credited to a Participant's HRA account as of the end of a coverage period against which liabilities have not been accrued during the coverage period which are not carried forward pursuant to the preceding shall be forfeited upon the earlier of (1) the end of the coverage period or (2) the date the Participant ceases to be a Participant in the HRA.

Any Participant who ceases to participate in the HRA-Related Medical Plan will simultaneously cease to be a Participant in the HRA.

APPENDIX D

SPECIFIC PROVISIONS APPLICABLE TO DIFFERENT CLASSES OF EMPLOYEES

Hourly Production Employees

Participation Begins:	With respect to benefits described in Section 4.4, 4.5, 4.6 (A), (B), (C), (D) and 4.7(A), the first day of the month following 30 continuous days of employment.
	With respect to benefits described in Section 4.6 (G), and (H) the first day of the month following 30 continuous days of employment
	With respect to benefits described in Section 4.6 (E), (F), (G), (H), (I) ,(J), and 4.7(C), the first day of the month following 90 continuous days of employment.
	With respect to benefits described in Section 4.7(B) the first day of employment

Benefits Available for Election:
The following benefits under Section 4.6 for employees who have not elected the Buy-Out Option described in Section 4.4.

Option #1 Austal USA PPO Plan
Option #2 Austal USA HRA Plan
Option #3 Spousal Opt-Out Plan
Option #4 Opt-Out Benefit

Dental

Option #1 High Option
Option #2 Opt-Out Benefit

Health FSA

Option #1 Dollar amount not greater than $2,750. effective July 1, 2020.
Option #2 No coverage

Dependent Care FSA

Option #1 Dollar amount not greater than $5,000.
Option #2 No coverage

Short-Term Disability

Option #1 Variable amount of coverage for $400 per month to 60% of salary (not to exceed $5,000 monthly benefits)
Option #2 No coverage

Voluntary Long-Term Disability

Option #1 Coverage of up to 60% of monthly income
Option #2 No coverage

Supplemental Life Insurance

Option #1 Coverage in units of $10,000 not to exceed 5 times annual salary
Option #2 No coverage

Dependent Life Insurance

Available when employee elects Supplemental Life Insurance

Spouse: Increments of $10,000 not to exceed $50,000
Child: Increments of $2,000 not to exceed $10,000

Critical Illness Insurance

Option #1 Coverage as available
Option #2 No coverage

International Medical Insurance

Option #1 Coverage as available
Option #2 No coverage

<u>Salary and Exempt Employees</u>

Participation Begins: With respect to benefits described in Section 4.4, 4.5, 4.6 (A), (B), (C), and (D), the first day of the month following the Employee's date of hire.

With respect to benefits described in Section 4.6 (G), and (H) the first day of the month following 30 continuous days of employment

With respect to benefits described in Section 4.6 (E), and (I), and 4.7(C), the first day of the month following 90 continuous days of employment.

With respect to benefits described in Section 4.7(B) the first day of employment

Benefits Available for Election:
The following benefits under Section 4.6:

Option #1 Austal USA PPO Plan
Option #2 Austal USA HRA Plan
Option #3 Spousal Opt-Out Plan
Option #4 Opt-Out Benefit

Dental

Option #1 Low Option
Option #2 High Option
Option #3 Opt-Out Benefit

Health FSA

Option #1 Dollar amount not greater than $2,750 effective July 1, 2020,
Option #2 No coverage

Dependent Care FSA

Option #1 Dollar amount not greater than $5,000.
Option #2 No coverage

Short-Term Disability

Option #1 Variable amount of coverage for $400 per month to 60% of salary (not to exceed $5,000 monthly benefits)
Option #2 No coverage

Supplemental Life Insurance

Option #1	Coverage in units of $10,000 not to exceed 5 times annual salary
Option #2	No coverage

Dependent Life Insurance

Available when employee elects Supplemental Life Insurance

Spouse:	Increments of $10,000 not to exceed $50,000
Child:	Increments of $2,000 not to exceed $10,000

Critical Illness Insurance

Option #1	Coverage as available
Option #2	No coverage

International Medical Insurance

Option #1	Coverage as available
Option #2	No coverage

This Appendix D shall be subject to modification without formal amendment of the Plan.

APPENDIX E

APPLICABLE INCORPORATED DOCUMENTS

APPLICABLE DOCUMENT	APPLICABLE BENEFIT
BCBS of Alabama - Austal USA PPO Plan	PPO Medical Benefits
UHC - Austal USA HRA Plan	Medical/HRA Account Benefits
Austal USA Dental High Option Plan Austal USA Dental Low Option Plan	Dental Benefits
United Healthcare Vision	Vision Benefits
Summary of Benefits provided by Optum Employee Assistance Plan	Employee Assistance Plan
Certificate of Coverage issued by Unum Life Insurance Company of America	Basic Group Term Basic Life Benefits, Accidental Death & Dismemberment Benefits
Certificate of coverage issued by UNUM	Supplemental Short Term Disability Benefits
Certificates of coverage issued by Unum Life Insurance Company	Long Term Disability Benefits
Certificate of Coverage issued by UNUM	Voluntary Life Benefits
Provident Life	Individual LTD Contracts
Protective Life	Individual Life Insurance Contracts
UNUM Critical Illness	Critical Illness Policies
Discovery Benefits	Flexible Spending Account and COBRA
United HealthCare Global	International Benefits
Austal MERP	Spousal Incentive HRA/Opt-Out

This Appendix E shall be subject to modification without formal amendment of the Plan.

APPENDIX F

EMPLOYEES OF THE EMPLOYER APPROVED TO HAVE ACCESS TO PROTECTED HEALTH INFORMATION

Deborah Knepton, Sr. Manager Compensation and Benefits Liz Brooks, Leave Coordinator

Sheryl Wainwright, Benefits Coordinator Natasha Adams, Sr. Benefits Administrator

Amanda Jarvis, Benefits Administrator

Corlette Davis, Benefits Administrator

This Appendix F shall be subject to modification without formal amendment of the Plan.

PREAMBLE AND EXECUTION

WHEREAS, Austal USA, LLC ("the Company") maintains medical, dental, employee assistance benefits, group life and accidental death and dismemberment, short term disability, long term disability, health care spending account, dependent care spending account and premium conversion benefits for its employees and their eligible dependents; and

WHEREAS, the Company desires to consolidate these benefits into one plan.

NOW, THEREFORE, by virtue and in exercise of the amending power reserved to the Board of Directors and pursuant to the authority delegated to the undersigned agent of the Company by resolutions adopted by its Board of Directors the Austal USA, LLC Group Health and Welfare Benefit Plan (the "Plan") is hereby adopted as a consolidated plan effective July 1, 2011.

IN WITNESS WHEREOF, the undersigned has caused the Plan to be executed by its duly authorized officer this 1st day of April, 2015

AUSTAL USA, LLC

By Brian Leathers

Title S-VP / CFO