

THE OCEAN SPRAY CRANBERRIES, INC.

WELFARE BENEFIT AND CAFETERIA PLAN

As Amended and Restated effective as of January 1, 2020

Including amendments through March 2017

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WHEREAS, Ocean Spray Cranberries, Inc. (hereinafter referred to as the "Sponsoring Employer") established and adopted the Ocean Spray Cranberries, Inc. Welfare Benefit and Cafeteria Plan (hereinafter referred to as the "Plan") for its employees; and

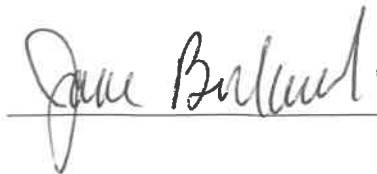
WHEREAS, several amendments to the Plan have been made since its adoption; and

NOW, THEREFORE, in consideration of the foregoing, the Plan is hereby amended and restated as effective as of January 1, 2020. It is the intention of the Sponsoring Employer that the Plan as herein amended and restated shall continue to be recognized as a qualified welfare and cafeteria plan under the Internal Revenue Code, including but not limited to Sections 104, 105, 106, and 125 of the Code.

IN WITNESS WHEREOF, OCEAN SPRAY CRANBERRIES, INC. has caused this document to be executed as of 10/30/19.

OCEAN SPRAY CRANBERRIES, INC.

By:



Attest:

Witness

ARTICLE I

Introduction

1.1 Purpose of Plan

The purpose of the Plan as established and maintained by Ocean Spray Cranberries, Inc. is to provide Eligible Employees with certain employee benefits via a Welfare Benefit Plan component and a Cafeteria Plan component. This booklet, called a Summary Plan Description (or SPD, for short), describes how the plan works and explains your rights if you enroll in the plan. It also serves as the plan document that governs how the programs are administered.

With regard to the Cafeteria Plan component, the intention of the Employer is that it qualify as a cafeteria plan within the meaning of Section 125 of the Code and that the benefits which an Eligible Employee elects to receive under the Cafeteria Plan component be excludable from the Eligible Employee's income under Section 125(a) and other applicable sections of the Code.

With regard to the Welfare Benefit Plan component, the Employer offers the plan for the exclusive benefit of and to provide benefits to Eligible Employees, their legal spouses and eligible Dependents and Non-Tax Dependents. Certain of these benefits are fully-insured and provided under insurance contracts with insurance carriers. Others are self-insured and administered under service contracts with service providers. These benefits (including information about who is eligible to receive benefits, the amount payable, required deductibles, co-payments, maximums, limitations, and exclusions, as applicable) are summarized in the insurance contracts, administrative agreements and evidence of coverage documents, which are collectively or individually referred to as "EOCs." Please refer to *Appendix A* for a list of the EOCs.

If there is a conflict between this Plan document/SPD and the EOCs with respect to the specific benefits provided, the following rules shall apply, to the extent not in conflict with applicable law:

- With respect to self-funded benefits, the formal plan document/SPD shall control; and
- With respect to insured benefits, the EOC shall control.

1.2 Effective Date

The Welfare Benefit Plan component was originally effective as of September 1, 1976. The Cafeteria Plan component was originally effective January 1, 1994. The entire Plan is hereby amended and restated effective as of ____ January 1, 2020 ____.

1.3 Appendices

Each Appendix forms a part of the Plan and its provisions shall supersede Plan provisions as necessary to eliminate any inconsistencies.

ARTICLE II

Definitions

2.1 Definitions

For purposes of this Plan, the following words and phrases, whether or not capitalized, have the meanings specified below, unless the context plainly requires a different meaning:

(a) “Administrator” or “Plan Administrator” means the Pension and Savings Committee of the Employer or such other persons as the Employer may appoint to administer the Plan.

(b) “Child” or “Children” means, for purposes of the Health Benefit under Section 3.3.4, the son(s), daughter(s), stepson(s), or stepdaughter(s) of the Participant, including any individual(s) legally adopted by the Participant, placed with the Participant for legal adoption by the Participant, or placed with the Participant as a foster child by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction, through the end of the month following his or her 26th birthday, regardless of whether the child qualifies as a Dependent.

(c) “COBRA” means the continuation of medical coverage that must be offered in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and underlying regulations, rulings, notices or other guidance.

(d) “Code” means the Internal Revenue Code of 1986, as amended from time to time, and the regulations promulgated thereunder.

(e) “Dependent” means an individual who qualifies as a dependent under Code Section 152 (as modified by Code Section 105(b)). The term also includes a domestic partner and/or the dependent child(ren) of the domestic partner who qualify as dependents of the Participant under Section 152 of the Internal Revenue Code of 1986, as amended, and for whom the Employer has (1) either (A) a valid affidavit of same/opposite sex domestic partnership (together with proof of 12 months’ joint residency) or (B) a certificate of state-recognized domestic partnership and (2) a valid declaration of tax status on file.

(f) “Employer” means Ocean Spray Cranberries, Inc. (in its capacity as employer of its employees) and any Participating Employer (in its capacity as employer of its employee).

(g) “ERISA” means the Employee Retirement Income Security Act of 1974, as amended from time to time, and the regulations promulgated thereunder.

(h) “Health Savings Account (HSA)” means an HSA that is established and maintained by an HSA-Eligible Employee through the HSA trustee or custodian selected by the Sponsoring Employer and offered in conjunction with the Employee’s enrollment in a High Deductible Health Plan sponsored by the Sponsored Employer.

(i) “Non-Tax Dependent” means a domestic partner and/or the child(ren) of the domestic partner who is eligible for coverage under the Welfare Benefit component and who is not a dependent of the Participant under Section 152 of the Internal Revenue Code of 1986, as amended; and provided, however, that only those domestic partners for whom the Employer has a valid affidavit of same/opposite sex domestic partnership and (together with proof of 12 months’ joint residency) or a certificate of state-recognized domestic partnership on file shall be considered Non-Tax Dependents. For purposes of the Health Benefit under Section 3.3.4, “child(ren) of the domestic partner” means the son(s), daughter(s), stepson(s), or stepdaughter(s) of the domestic partner, including any individual(s) legally adopted by the domestic partner, placed with the domestic partner for legal adoption by the domestic partner, or placed with the domestic partner as a foster child by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction, through the end of the month following his or her 26th birthday, regardless of whether the child qualifies as a Dependent of the domestic partner.

(j) “Participating Employer” means any employer that is affiliated with Ocean Spray Cranberries, Inc. and has adopted this Plan for its employees with the approval of the Sponsoring Employer.

(k) “Plan” means this instrument, including all amendments thereto.

(l) “Plan Year” means the twelve consecutive month period coincident with each calendar year.

(m) “Sponsoring Employer” means Ocean Spray Cranberries, Inc., in its capacity as sponsor of this Plan, and any successor which shall maintain this Plan, and any predecessor which has maintained this Plan.

ARTICLE III

CAFETERIA PLAN COMPONENT

3.1 Participation in Cafeteria Plan Component

3.1.1 Eligibility If you are an Eligible Employee, you are eligible to participate in the Cafeteria Plan component as of your date of employment. You are an “Eligible Employee” if you meet the following requirements while employed by the Employer:

- You are regularly scheduled to work at least 22.5 hours per week (without regard to retroactive classification for other purposes such as payroll taxes);
- You are not a leased employee (within the meaning of Code Section 414(n));
- You are not a temporary/seasonal employee;
- You are not a union employee at the Markham, Washington facility.
- The Employer also provides health benefits for any otherwise excluded employee as and to the extent required under the Affordable Care Act in accordance with Employee policy. The annual look-back period is shown in

the Look-Back Period Measurement Policy attached.

3.1.2 Application to Participate, Benefit Elections

(a) Initial Election

If you are eligible to participate in the Cafeteria Plan component, in order to become a “Participant” you must complete an electronic application to participate, an election of benefits form, and a “Salary Redirection Agreement” which is an agreement between you and the Employer under which you agree to reduce your annual compensation that you have neither actually nor constructively received and to have such amounts contributed by the Employer to the Plan on your behalf, all of which the Administrator will furnish to you during the annual Election Period. The elections made on benefit election forms are irrevocable until the end of the applicable Plan Year and you cannot change them unless you are entitled to do so pursuant to Section 3.4 hereof. The Salary Redirection Agreement is effective for the first pay period beginning on or after the effective date of participation.

Notwithstanding the foregoing, if you are eligible to participate in the Cafeteria Plan and are covered by the Employer’s insured benefits under Article IV of the Plan you shall automatically become a Participant to the extent of the premiums for such insurance unless you elect not to participate in the Plan during the annual Election Period.

If you waive medical coverage for you and your eligible Dependents for the entire calendar year by completing the appropriate form and provide documentation of alternate coverage, you will be entitled to a \$1000 annualized payroll credit, which will constitute taxable income to you.

(b) Subsequent Annual Elections

During the enrollment period prior to each subsequent Plan Year, which is normally held in October and your elections are effective the following January 1, you will be given the opportunity to elect, which benefit options you wish to select. Any such election shall be effective for any benefit expenses incurred during the Plan Year which follows the end of the election period. With regard to subsequent annual elections, the following options shall apply:

(i) If you failed to initially elect to participate, you may elect different or new benefits under the Plan during the election period;

(ii) You may terminate your participation in the Plan by notifying the Administrator in writing during the Election Period that you do not want to participate in the Plan for the next Plan Year;

(iii) If you elect not to participate for the Plan Year following the Election Period, you will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 3.4.

(c) Failure to Make Elections

With regard to all benefits available under the Plan that are paid 100% by the Employer (e.g. Basic Life Insurance), if you fail to complete a new benefit election form by the end of the applicable Election Period, you shall be deemed to have made the same benefit elections as are then in effect for the current Plan Year.

With regard to benefits available under the Plan for which premium expenses apply – including medical, dental, and vision coverage - if you fail to complete a new benefit election form by the end of the applicable Election Period, you shall be deemed to have made the same benefit elections as are then in effect for the current Plan Year.

With regard to flexible spending accounts, you must enroll for coverage under the Plan during each annual Election Period. If you fail to complete a new benefit election form by the end of the applicable Election Period, you shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further salary redirections shall be authorized or made for the subsequent Plan Year for such benefits, your coverage elections will not continue from the previous year, your coverage will terminate, and you will not be able to enroll until the next Election Period unless you have a qualified change in status or are eligible for a special enrollment.

With regard to health savings accounts, an Employee may elect to increase, decrease, or revoke a pre-tax election to make contributions for the HSA Program described in Appendix C at any time on a prospective basis. Any change in an HSA election shall become effective not later than the next available payroll date following the Plan Sponsor's receipt of a completed election change form. No other election changes under the Plan can occur as a result of a change in an HSA election except as otherwise described in Section 3.1.2.

3.1.3 Termination of Participation

You are no longer eligible to participate in the Cafeteria Plan if the Plan is terminated for any reason. Further events that trigger ineligibility are as follows:

(a) Change of Employment Status

If you cease to be eligible to participate because of a change in employment status or classification (other than through termination of employment), you shall become a limited Participant in this Plan for the remainder of the Plan Year in which such change of employment status occurs. As a limited Participant, no further salary redirection may be made, and, except as otherwise provided herein, all further benefit elections shall cease, subject to your right to continue coverage under the Health Benefit EOC. If you

later become an Eligible Employee, then you may again become a full Participant in this Plan, provided you otherwise satisfy the participation requirements set forth in this Article III as if you were a new Employee and made an election in accordance with Section 3.1.2.

(b) Termination of Employment

If your employment with the Employer is terminated for any reason other than death, your participation in the benefit options shall be governed in accordance with the following:

(i) **Health Benefit and Insurance Benefits.** With regard to the Health Benefit and any insurance benefits, your participation in the Plan shall cease, subject to your right to continue coverage under the Health Benefit EOC. You and your covered eligible Dependents might have the right to continue medical coverage temporarily under COBRA, and to elect between receiving severance pay and using the severance pay to pay the COBRA premiums for the Health Benefit, Dental Benefit, and/or Vision Benefit.

(ii) **COBRA applicability.** With regard to the Health Care Flexible Spending Account, you may submit claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Care Flexible Spending Account have already been made. Thereafter, the health benefits under this Plan, including the Health Care Flexible Spending Account, shall be applied and administered consistent with such further rights you and your Dependents may be entitled to pursuant to the continuation coverage requirements of Code Section 4980B.

(c) Death

If you die, your participation in the Plan shall cease. In no event may reimbursements be paid to someone who is not your spouse or Dependent. If the Plan is subject to the continuation coverage provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Care Flexible Spending Account.

3.2 Contributions to the Cafeteria Plan

3.2.1 Salary Redirection

Benefits under the Plan shall be financed by salary redirection sufficient to support benefits that you have elected hereunder and to pay your premium expenses. The amount of such salary redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. If you are a new Participant, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following your entry date up to and including the last day of the Plan Year. These contributions shall be allocated to the accounts

established under the Plan pursuant to the elections you make under this Article III. A Participant may elect to make pre-tax contributions to the HSA to cover “qualified eligible medical expenses,” as set forth in Code Section 223(d)(2), subject to the limitations in Appendix C.

You may revoke a benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Section 3.4 and consistent with the rules and regulations of the Department of the Treasury. Salary redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2.2 Application of Contributions

As soon as reasonably practical after each payroll period, the Employer shall apply the salary redirection to provide the benefits elected by you. Any contribution made or withheld for the Health Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for your premium expenses shall likewise be credited for the purpose of paying premium expenses.

3.3 Cafeteria Plan Benefits

3.3.1 Benefit Options

As a Participant, you may elect any one or more of the following optional benefits:

(a) **Health Care Flexible Spending Account**

In addition, if you affirmatively elect any of the following benefits during the annual Election Period, you will have a sufficient portion of your salary redirection applied to the following benefits:

(b) **Health Benefit (including Prescription)**

(c) **Dental Insurance Benefit**

(d) **Vision Insurance Benefit**

3.3.2 Health Care Flexible Spending Account Benefit

You may elect to participate in the Health Care Flexible Spending Account option, in which case Section 3.5 shall apply.

3.3.3 Health Benefit

You may elect to be covered under the Health Benefit EOC for yourself, your spouse, your Children, your Dependents, and your Non-Tax Dependents. The Sponsoring Employer may select suitable contracts for use in providing this Health Benefit, which may include prescription drug coverage either as part of the medical coverage EOC or as a stand-alone benefit. These Health Benefit contracts will provide uniform benefits for all Participants electing this benefit. The rights and conditions with respect to the benefits payable from such medical and prescription drug coverage contracts shall be determined therefrom, and such medical and prescription drug contracts shall be incorporated herein by reference

3.3.4 Dental Insurance Benefit

You may elect to be covered under the Employer's dental insurance contract. In addition, you may elect either individual, employee plus one, or family coverage under such insurance contract. The Sponsoring Employer may select suitable dental insurance contracts for use in providing this dental insurance benefit, which policies will provide uniform benefits for all Participants electing this benefit. The rights and conditions with respect to the benefits payable from such dental insurance contracts shall be determined therefrom, and such dental insurance contracts shall be incorporated herein by reference.

3.3.5 Vision Insurance Benefit

You may elect to be covered under the Employer's vision insurance contract. In addition, you may elect either individual, employee plus one, or family coverage. The Sponsoring Employer may select suitable vision insurance contracts for use in providing this vision insurance benefit, which policies will provide uniform benefits for all Participants electing this benefit. The rights and conditions with respect to the benefits payable from such vision insurance contracts shall be determined therefrom, and such vision insurance contracts shall be incorporated herein by reference.

3.3.6 Nondiscrimination Requirements

It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125. It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees (as described in Code Section 416(i)(1)) in amounts that exceed 25% of the aggregate of such benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reduce contributions or non-

taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner.

3.4 Change in Status

Please note: you may not change your selected benefit tier (PPO 80, PPO 80 Low or HDHP w/HSA) for the Health Benefit mid-year, even if you experience a change in status. Once a tier is selected at open enrollment, it remains in place until the next open enrollment.

3.4.1 Change in status defined

You may change a benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under the rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is your divorce, annulment or legal separation from your spouse, the death of your spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and your election under the Plan is to cancel Health Benefit coverage for any individual other than the one involved in such event. In addition, if you, your spouse or Dependent gains or loses eligibility for coverage, then an election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if you, your spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then you may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

- (a) Legal Marital Status: Events that change your legal marital status, including marriage, divorce, death of a spouse, legal separation or annulment;
- (b) Number of Dependents: Events that change your number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;
- (c) Employment Status: Any of the following events that change the employment status of you, your spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of

absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the Plan, then that change constitutes a change in employment under this subsection;

(d) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes your Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(e) Residency: A change in the place of residence of you, your spouse or Dependent that would lead to a change in status.

3.4.2 Special enrollment rights

Notwithstanding subsection 3.4.1, you may change an election for Health Benefit coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

3.4.3 Qualified Medical Support Order

Notwithstanding subsection 3.4.1, in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires health coverage for your child (including a foster child who is your Dependent):

(a) The Plan may change an election to provide coverage for the child if the order requires coverage under the plan; or

(b) You shall be permitted to change an election to cancel coverage for the child if the order requires the former spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

3.4.4 Medicare or Medicaid

Notwithstanding subsection 3.4.1, you may change elections to cancel health coverage for you or your spouse or Dependent if you or your spouse or Dependent is enrolled in the health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If you or your spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that

individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

3.4.5 Cost increase or decrease

If the cost of an elected benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, your salary redirections for that benefit. Alternatively, if the cost of an elected benefit package option increases significantly, you may either make corresponding changes in your payment or revoke your election and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by you or an action taken by the Employer.

3.4.6 Loss of coverage

If the coverage under an elected benefit is significantly curtailed or ceases during a Plan Year, you may revoke your election of such benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

3.4.7 Addition of a new benefit

If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then you may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, if you are an Eligible Employee who is not participating in the Plan, you may opt to become a Participant and elect the new or newly improved benefit package option.

3.4.8 Loss of coverage under certain other plans

You may make a prospective election change to add group health coverage for you, your spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

3.4.9 Change of coverage due to change under certain other plans

You may make a prospective election change that is on account of and corresponds with a change made under the plan of your spouse's, former spouse's or Dependent's employer if (1)

the cafeteria plan or other benefits plan of the spouse's, former spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a spouse's, former spouse's or Dependent's employer.

3.4.10 Health Care FSA cannot change due to change in Health Benefit coverage

You will not be permitted to change an election to the Health Care Flexible Spending Account as a result of a cost or coverage change under any Health Benefit.

3.4.11 Domestic Partner Changes

In the event a domestic partner and/or the dependent child(ren) of the domestic partner cease to be a Dependent during the period a valid affidavit of same/opposite sex domestic partnership or certificate of state-recognized domestic partnership and declaration of tax status is on file with the Employer, then no prospective election change is permitted and income will be imputed based on the fair market value of coverage in accordance with the Sponsoring Employer's policies. In the event a domestic partner and/or the dependent child(ren) of the domestic partner cease to be either a Dependent or Non-Tax Dependent as a result of a change in the domestic partner status which results in a loss of benefits, a prospective benefit election change is permitted and continuation coverage will be extended in accordance with the Sponsoring Employer's policies.

3.4.12 FMLA

If you take leave under the Family and Medical Leave Act, you may revoke your existing election for Health Benefits or change that election due to change in status (except your election of a benefit tier, see above) and revoke or change your existing benefit for Health Care Flexible Spending Account. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Care Flexible Spending Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. Alternatively, your maximum amount will be reduced proportionately for the time that you were gone. The expenses you incur during the time you are not in the Health Care Flexible Spending Account are not reimbursable. If you continue your coverage during your unpaid leave, you may pre-pay for the coverage or you may pay for your coverage when you return.

3.5 Health Care Flexible Spending Account

3.5.1 Establishment of Plan

The "Health Care Flexible Spending Account" is the account established for you pursuant to this Plan to which part of your salary redirection may be allocated and from which all allowable Medical Expenses incurred by you, your spouse and your Dependents may be

reimbursed. It is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. If you elect to participate in this Health Care Flexible Spending Account, you may submit claims for the reimbursement of certain Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Care Flexible Spending Account. Periodic payments reimbursing Participants from the Health Care Flexible Spending Account shall in no event occur less frequently than monthly.

“Medical Expenses” means any expense for medical care within the meaning of the term “medical care” as defined in Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury regulations thereunder, and not otherwise used by you as a deduction in determining your tax liability under the Code; provided, however, that Medical Expenses do not include the cost of over-the-counter drugs or medications, other than insulin, without a prescription. “Medical Expenses” can be incurred by you, your spouse and your Dependents. You may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of your spouse or individual policies maintained by you or your spouse or Dependent. You may not be reimbursed for “qualified long-term care services” as defined in Code Section 7702B(c).

3.5.2 Forfeitures

Except as provided in this Section, the amount in the Health Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year) shall be forfeited and credited to the benefit plan surplus, and you shall have no further claim to such amount for any reason, subject to Section 3.5.7. You may carryover to the immediately following plan year up to \$500 of any amount remaining unused as of the end of the plan year in the Health Care Flexible Spending Account, and may use the carryover amount to pay or reimburse medical expenses (as defined in Section 3.5.1) incurred during the entire Plan Year to which it is carried over. For this purpose, the amount remaining unused as of the end of the Plan Year is the amount unused after medical expenses have been reimbursed at the end of the run-out period for the Plan Year as provided in Section 3.5.6(d).

3.5.3 Limitation On Allocations

Notwithstanding any provision contained in this Health Care Flexible Spending Account to the contrary, you may allocate no more than the annual maximum contribution as designated each year by the IRS to the Health Care Flexible Spending Account in any Plan Year; provided, however, that the carryover permitted under Section 3.5.2 does not count against the annual allocation limit.

3.5.4 Nondiscrimination Requirements

(a) **Intent to be nondiscriminatory.** It is the intent of this Health Care Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Care Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner.

3.5.5 Coordination with Cafeteria Plan

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Care Flexible Spending Account. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

3.5.6 Health Care Flexible Spending Account Claims

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by you, your spouse and your Dependents shall be reimbursed during the Plan Year even though the submission of such a claim occurs after your participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when you are provided with the medical care that gives rise to the medical expenses, not when you are formally billed or charged for, or pay for the medical care.

(b) **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to you for all allowable Medical Expenses, up to a maximum of the amount designated by you for the Health Care Flexible Spending Account for the Plan Year. Reimbursements shall be made available to you throughout the year without regard to the level of salary redirections which have been allocated to the fund at any given point in time. Furthermore, you shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering you and/or your spouse or Dependents.

(c) **Payments.** Reimbursement payments under this Plan shall be made directly to you. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, you shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Care Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is

administratively practicable; provided however, that if you fail to submit a claim on or before March 31 of the calendar year after the end of the Plan Year in which the claim was incurred, those Medical Expense claims shall not be considered for reimbursement by the Administrator. Claims for expenses should be submitted to:

Sentinel Financial Group
55 Walkers Brook Drive, Suite 100
P.O. Box 5000
Reading, MA 01867

3.5.7 Debit Cards

You may use debit and/or credit (stored value) cards provided by the Administrator and the Plan for payment of Medical Expenses other than over-the-counter drugs and medications, which must be substantiated by the presentation of a receipt plus a copy of the applicable prescription. You must certify that such card will only be used for Medical Expenses and that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that you will not seek reimbursement from any other plan covering health benefits. Cards will be issued upon your date of Participation and reissued periodically while you remain a Participant in the Health Care Flexible Spending Account. Such card shall be automatically cancelled upon your death or termination of employment, or if you have a change in status that results in your withdrawal from the Health Care Flexible Spending Account.

The dollar amount of coverage available on the card shall be the amount elected by you for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year. The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.

The cards shall only be used for Medical Expense purchases at these providers, such as co-payments for doctor and other medical care, purchases of drugs (other than over-the-counter drugs and medications), and purchases of medical items such as eyeglasses, syringes, crutches, etc.

Card purchases shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in IRS guidance. All charges shall be conditional pending confirmation and substantiation.

If a purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card:

- (a) Repayment of the improper amount by you;

- (b) Withholding the improper payment from your wages or other compensation to the extent consistent with applicable federal or state law;
 - (c) Claims substitution or offset of future claims until the amount is repaid;
- and
- (d) if subsections (a) through (c) fail to recover the amount, consistent with the Sponsoring Employer's business practices, the Employer may treat the amount as any other business indebtedness.

3.5.8 Qualified Reservist Distribution.

Notwithstanding anything to the contrary herein, a Participant who is a member of a reserve component of the United States Armed Forces and is ordered or called to active duty for a period for 180 days or more or for an indefinite period may receive a refund of amounts contained in his or her Health FSA, provided the request is made during the period beginning with the date of the order or call to active duty and ending on the last day of the plan year (or grace period if applicable). The amount refunded to the Participant shall be the amount contributed to the Health FSA as of the date of the Participant's refund request minus any reimbursements received by the Participant from his/her Health FSA as of the date of the refund request. Once a refund request has been made by a Participant, he or she may no longer submit claims for reimbursement to the Health FSA nor may he or she make any further contributions to the Participant's Health FSA. Participant shall receive the refund within sixty (60) days of the receipt of the Participant's request. Any amount refunded to Participant pursuant to this Section 3.5.8 will be considered income to the Participant and included as wages subject to applicable employment taxes.

3.6 Application of Benefit Plan Surplus

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

ARTICLE IV

Welfare Benefit Plan Component

4.1 Benefits, Eligible Employees, and Participation

4.1.1 Benefits

The Plan provides the following benefits:

- Medical (with Prescription);
- Dental;
- Vision;
- Short-Term Disability;
- Long-Term Disability;
- Basic Life Insurance;
- Optional Life Insurance;
- Dependent Life Insurance;
- Accidental Death and Dismemberment Insurance;
- Supplemental Accidental Death and Dismemberment Insurance;
- Long-Term Care Insurance; and
- Business Travel Accident Insurance.
- Critical Illness Insurance
- Hospital Care Coverage

4.1.2 Eligible Employees

You are an Eligible Employee if you are classified by the Employer as an employee (without regard to retroactive classification for other purposes such as payroll taxes) other than a leased employee (within the meaning of Code Section 414(n)), a temporary/seasonal employee, or a union employee at the Markham, Washington facility. The Employer also provides health benefits for any otherwise excluded employee as and to the extent required under the Affordable Care Act in accordance with Employer policy. The look-back period is

You must be scheduled to work at least 22.5 hours per week for health, dental and vision benefits.

For short-term and long-term disability, basic life insurance, optional life insurance, dependent life insurance, accidental death and dismemberment insurance, supplemental accidental death and dismemberment insurance, long-term care insurance, hospital care, critical illness and business travel accident insurance benefits under the Plan, you must be scheduled to work at least 30 hours per week, except that to be eligible for basic life and basic accidental death and dismemberment insurance and business travel accident insurance benefits you must be

regularly scheduled to work 22.5 hours per week (for basic life and basic AD&D insurance) or 37.5 hours per week as a salaried employee (for business travel accident insurance). Union employees at the Middleboro, Massachusetts facility are not eligible for long-term disability insurance.

4.1.3 Qualified Medical Child Support Orders

The Plan will provide medical, prescription drug, dental and/or vision benefits as required by any qualified medical child support order (“QMCSO”) (as defined in ERISA Section 609(a)), and will provide benefits to dependent children of participants or beneficiaries, in accordance with ERISA Section 609. If a divorce decree or QMCSO requires you to provide coverage, dependent children may also include children who do not live with you and for whom you do not provide financial support. You may obtain a copy of the Plan’s procedures governing QMCSO determinations, free of charge, by contacting the Plan Administrator.

4.1.4 Commencement of Coverage

Coverage for the medical, dental and vision benefits under the Plan begin on your date of hire, provided you timely and properly enroll for these benefits. Coverage for the short-term disability, long-term disability, basic life insurance, and basic travel accident insurance benefits begins on your date of hire, provided that you are actively at work on that date. Coverage for optional life insurance, dependent life insurance, accidental death and dismemberment insurance, supplemental accidental death and dismemberment, health care flexible spending, hospital care, critical illness and long-term care insurance begins on the first day you are eligible for coverage, provided that you are actively at work on that day and have enrolled in the coverage.

PLEASE NOTE that union employees at our Middleboro, Massachusetts facility hired after March 1, 2006, must wait one year before becoming eligible for short-term disability benefits and their benefit is limited to \$350.00 per week. Union employees at our Middleboro, Massachusetts facility are eligible only for a maximum benefit of \$25,000 under the basic life insurance and accidental death and dismemberment benefits). Coverage for all applicable benefits under the Plan for union employees at our Kenosha, Wisconsin facility begins 31 days from the date of hire.

4.1.5 Initial Enrollment

You will become a participant in the Plan, provided that you make the appropriate benefit elections as prescribed by the Plan Administrator and submit a completed enrollment form to the Plan Administrator. To receive Health Benefit coverage, or coverage under dental, vision, optional life insurance, dependent life insurance, accidental death and dismemberment insurance, supplemental accidental death and dismemberment insurance, flexible spending, hospital care and critical illness and long-term care insurance under the Plan, you must enroll yourself and your eligible Dependents and Non-Tax-Dependents (enrollment for short-term disability, long-term disability, basic life insurance, and business travel accident insurance benefits is automatic).

You must enroll for coverage under the Plan within 30 days of the date you first become eligible. If your enrollment forms are received more than 30 days after the date you are first

eligible, you will not be able to enroll until the next Election Period unless you have a qualified change in status or are eligible for a special enrollment. For more information on the change in status rules, please refer to Section 3.4.

4.1.6 Annual Enrollment

If you are an Eligible Employee, you may enroll in, change your coverage level, or waive coverage for benefits during the annual Election Period which is normally held in October and your elections are effective the following January 1. Your coverage elections made during the annual Election Period are binding and will remain in effect until the next annual Election Period unless you have a qualified change in status or are eligible for a special enrollment.

With regard to all benefits, with the exception of Health Care Flexible Spending, available under the Plan if you fail to complete a new benefit election form by the end of the applicable Election Period, you shall be deemed to have made the same benefit elections as are then in effect for the current Plan Year. Salary redirections shall therefore continue to be made for the subsequent Plan Year for such benefits.

With regard to Health Care flexible spending accounts you must enroll for coverage under the Plan during each annual Election Period. If you fail to enroll in this coverage by the end of the applicable Election Period, you shall be deemed to have elected not to participate in the Health Care flexible spending account for the upcoming Plan Year. and you will not be able to enroll until the next Election Period unless you have a qualified change in status or are eligible for a special enrollment.

4.1.7 Waiver of Coverage

You may elect to waive coverage for yourself and your Dependents each year by completing the appropriate form and/or failing to enroll during annual enrollment. A waiver of coverage will remain in effect during a year until you affirmatively elect coverage either during the next annual Election Period or upon the occurrence of a change in status or entitlement to special enrollment rights, as described in Section 3.4. If you waive medical coverage for you and your eligible Dependents for the entire calendar year by completing the appropriate form and provide documentation of alternate coverage, you will be entitled to a \$1000 annualized payroll credit, which will constitute taxable income to you.

4.1.8 Cost of Coverage

You and the Employer share the cost of coverage for certain benefits under the Plan. Your portion of the cost varies based on which coverage you elect. Your cost is deducted from your pay on a pre-tax basis; you may pay for COBRA continuation coverage on a pre-tax basis from severance pay. This means that generally your contributions come out of your pay before federal income and employment taxes are deducted. Pre-tax contributions reduce your gross salary, which lowers your taxable income and, therefore the amount of income tax you must pay. By paying lower taxes, you save money. In most states, you also pay no state taxes on your contributions. Please consult your tax advisor regarding your specific situation.

Please note that you will not be paying Social Security taxes on your contribution for Plan coverage. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these payments. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the Plan will normally be greater than any eventual reduction in Social Security benefits. Your payroll cost does not include your costs for any applicable deductibles, co-pays, co-insurance, out-of-network charges, or non-covered items.

For Eligible Employees, the costs of short-term disability, basic life insurance, basic accidental death and dismemberment insurance, supplemental additional accidental death and dismemberment insurance, and business travel accident benefits shall be entirely paid for by the Employer. The cost of optional life insurance, dependent life insurance, supplemental accident death and dismemberment, healthcare flexible spending accounts, hospital care, critical illness and long-term care insurance is entirely paid for by Eligible Employees on an after-tax basis. The Employer makes no contributions toward the cost of the coverage. Eligible Employees have a choice with respect to who pays for long-term disability coverage, except that Eligible Employees who hold director level positions and above must pay the cost of long-term disability coverage on an after-tax basis. Eligible Employees may elect to have the Employer pay the coverage premium, in which case any future long-term disability benefit payments will be taxable income to the Eligible Employee. In the alternative, Eligible Employees may elect to pay the cost of the long-term disability premiums themselves on an after-tax basis, in which case any future long-term disability benefit payments will not be taxable and the so-called “three-year look back” rule will not apply.

The costs of medical and dental coverage are split between the Employer and Eligible Employees, with the employee share being paid on a pre-tax basis. If you waive medical coverage for you and your eligible Dependents for the entire calendar year, you will be entitled to a \$1,000 annualized payroll credit, which will constitute taxable income to you. Vision coverage costs are paid entirely by eligible employees on a pre-tax basis. The Employer reserves the right to change the cost-sharing allocation at any time for benefits under this Plan. If the cost of a Plan benefit increases or decreases during a Plan year, your contributions (and corresponding salary reduction) may be affected automatically. If the change in cost is significant, you may be afforded the right to change or rescind your benefit election, as described in Section 3.4.

Please note that if coverage for Non-Tax Dependents is elected and paid for on a pre-tax basis, the cost of the coverage will be imputed and taxed to you in accordance with applicable laws.

4.1.9 Termination of Coverage

Your coverage under the Plan terminates as of the earlier of the following dates: (1) the date you fail to satisfy the requirements of an Eligible Employee; (2) the date you terminate employment with the Employer; (3) the date you fail to elect coverage during an Election Period (for any coverage other than Basic Life Insurance) and/or waive coverage under the Plan (for any coverage); or (4) the last day of the month in which you fail to pay the applicable premium or coverage cost when due. Other circumstances that can result in the termination, reduction, loss

or denial of benefits (for instance, exclusions due to preexisting conditions, and exclusions for certain medical procedures) are described in your EOCs.

Coverage under the Plan for your eligible Children, Dependents, and Non-Tax Dependents terminates when your coverage terminates. Coverage will also cease for other reasons specified in the EOCs, such as divorce, Child attains age limit, etc. Benefits will also cease for you and your eligible Children, Dependents, and Non-Tax Dependents on termination of the Plan.

Depending on the reason why coverage was terminated, you and your covered eligible Children, Dependents, and Non-Tax Dependents might have the right to continue medical, dental, or vision coverage temporarily under COBRA or under a portability plan or conversion right under a particular option. A terminated employee who is eligible for coverage under COBRA may elect to receive unreduced severance pay, or to use a portion of their severance pay for the required premiums for COBRA continuation coverage of the Health Benefit, Dental Benefit, and/or Vision Benefit. Many insurers will permit you to continue coverage on an individual policy. Conversion rights may also be available to your eligible Children, Dependents, and Non-Tax Dependents when they may not otherwise qualify for Health Benefits under normal circumstances. Therefore, the cost of the coverage is usually high and the conversion plans, prescribed by the state insurance regulations, will not offer the same comprehensive coverage as the Plan. For that reason, you should also contact other insurance companies so you can be sure you are getting the best coverage for your money. Refer to your EOCs for more information on portability plan rights and converting to an individual policy.

4.1.10 Coordination of Benefits

If you or any of your eligible Children, Dependents, and Non-Tax Dependents has coverage under any group medical or dental plan, the benefits under this Plan are coordinated with the benefits of the other plan. The Plan's coordination of benefit rules are summarized in the applicable EOCs. Please refer to *Appendix A* for a list of the EOCs.

4.1.11 Lost Participants and Beneficiaries

If the Plan Administrator is unable to locate any person to whom a benefit payment under a self-insured Plan component has been attempted, such payment amount shall be forfeited and applied to other Plan purposes after the expiration of 180 days following the date the last attempted payment is returned undeliverable; provided if the person to whom such payment was attempted subsequently appears and makes demand for such payment within two (2) years of the date the last attempted payment is returned undeliverable, the Plan Administrator shall direct that such payment be made, without interest unless required by law.

4.2 Rights of Subrogation and Reimbursement

4.2.1 Coverage for Injuries Caused by You or Other Parties

When you are injured or become ill because of the actions of yourself or a third party, the Plan may cover your eligible medical or dental expenses. However, to receive coverage, you

must notify the Plan that your illness or injury was caused by yourself or another party, and you must follow special Plan rules.

4.2.2 Right of Subrogation

The first rule is the **right of subrogation**. Subrogation means the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. The Plan's right of subrogation provides that if an injury or illness is your or someone else's fault, the Plan has the right to recover expenses it pays for that illness or injury directly from any of the sources of payment listed later in this section.

To exercise its right of subrogation, the Plan or the Plan Administrator (or any party designated by the Plan Administrator) may, in its discretion:

- place a first-dollar equitable lien or constructive trust for 100% of the benefits paid by the Plan against any responsible party or other third party recovery you receive to the extent the Plan paid benefits for the sickness or injury;
- bring an action on its own behalf or on your behalf against any responsible party or third party involved in the sickness or injury to recover 100% of the benefits paid by the Plan; or
- suspend the payment of any Plan benefits pending receipt from you of any acknowledgement, agreement, authorization, waiver or release it considers necessary to exercise its rights or privileges under the Plan.

4.2.3 Right of Reimbursement

The second rule is the Plan's **right of reimbursement**. If you receive any payment from a responsible party or third party (through a judgment, settlement or otherwise) when an injury or illness is your or someone else's fault, you must pay the Plan back *first, in full*, for 100% of any medical or dental expenses the Plan has paid to you or on your behalf. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for medical or dental expenses. Furthermore, you must pay the Plan back regardless of whether the responsible party admits liability and regardless of whether you have been made whole. In addition, you are responsible for payment of all of your attorneys' fees and court costs associated with any settlement or judgment you receive from a responsible party or third party, not the Plan. If any money is left over, you may keep it.

If you do not repay the Plan within seven (7) days after you receive a settlement or judgment from a responsible party or third party, the Plan requires you to pay interest in the amount of one and one half percent (1½ %) of the total amount of benefits paid per month. In addition, the Plan will not pay any attorneys' fees or costs associated with a lawsuit without the written permission of the Plan Administrator or any entity designated by the Plan Administrator.

4.2.4 Sources of Payment

The Plan's sources of payment through subrogation or reimbursement are as follows:

- money from a responsible party or third party that you, your dependents, your guardian or other representatives or beneficiaries receive or are entitled to receive;
- any constructive trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your dependents, your guardian or other representatives or beneficiaries receive; and
- any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable.

4.2.5 Your Responsibilities

You have the duty to cooperate fully with the Plan, the Plan Administrator and any party designated by the Plan Administrator if the Plan's rights of subrogation or reimbursement are asserted, including the execution and delivery of any documents the Plan may require or to appear in court for a deposition or testimony, if necessary.

4.2.6 Enforcement by the Plan

The Plan may enforce its rights of subrogation or reimbursement by requiring you, your dependents, your guardian or other representatives or beneficiaries to present a claim/lawsuit to any of the sources of payment listed previously to recover expenses that you or they may be entitled to. The Plan, the Plan Administrator and any entity designated by the Plan Administrator may suspend payment of future Plan benefits if you do not cooperate and comply with its rights of subrogation and reimbursement, or if you take any action that prejudices the Plan's rights of subrogation and reimbursement.

The Plan's rights of subrogation and reimbursement for 100% of all benefits paid, first-dollar, will not be reduced by any equitable defenses that may be raised by you or the third party responsible for your injury or illness, including but not limited to liability or other insurance covering the third party; any common fund doctrine; contributory or comparative negligence doctrine or statute; uninsured or underinsured motorist rules or statutes; medical payment; personal injury protection insurance; or no-fault insurance.

If the Plan has not yet paid benefits relating to an injury or illness that was caused by you, a responsible party or a third party, the Plan may reduce or deny future benefits relating to that injury or illness on the basis that you, your dependents, your guardian or other representatives or beneficiaries received compensation from the responsible party or third party. In addition, any amount due the Plan under its rights of subrogation or reimbursement may be off-set in the Plan Administrator's discretion against any other present or future medical and/or dental expense benefits payable to you or your dependents or beneficiaries.

The Plan has the right to file suit against you to recover 100% of its reimbursement right, and you will be required to pay the Plan's attorneys' fees and court costs related to any such suit.

The Plan is *not* required to pay medical or dental expenses for any past illnesses or injuries that are settled (through a judgment, settlement or otherwise). The Plan's rights of subrogation and reimbursement apply even if the original illness or injury happened before your coverage under the Plan commenced.

4.2.7 Additional Information

Any questions related to your duties and responsibilities under the Plan's subrogation and reimbursement rights may be directed to the Plan Administrator.

ARTICLE V

Claims and Appeals

5.1 Claim and Appeal Procedures

The discussion below outlines the general claim and appeal procedures that apply to benefit claims under the Plan, as specified by the Department of Labor. If you file a claim for insured benefits, you should follow the specific claim and appeal procedures described in each EOC. Please refer to Appendix A of this SPD for a list of EOCs. In the event an EOC does not contain a claims procedure, the procedures detailed below will govern those claims. In addition, if you are entitled to additional claim rights under ERISA or if ERISA requires the Plan Administrator to comply with additional claim rules and such rules and/or rights are not reflected in an EOC's claims procedure, the additional claim rights and rules detailed below and in Department of Labor regulations, including but not limited to 29 CFR §§ 2560.503-1 and 2590.715-2719, shall apply to bring the EOC claims procedure into compliance. Coverage under the Plan is offered under both self-insured and fully-insured options. The claim and appeal procedures vary depending on the type of coverage and type of benefit you have, and whether the coverage is provided under a self-insured or a fully-insured option. Any Participant or Dependent, or an authorized representative on behalf of a Participant or Dependent, may assert a claim for benefits. Throughout this Article V, any of these individuals are referred to generally as "the Claimant." The "Claims Reviewer" is the individual or entity assigned to review claims or appeals. Where an EOC's procedures specify that claims be sent to an insurer or third party administrator, then the insurer or third party administrator shall be the Claims Reviewer for purposes of the procedures that follow. Where an EOC's procedures do not contain any claims procedure, then the following procedures shall apply with the Plan Administrator (or its delegate) acting as the Claims Reviewer for all internal claims and appeals.

5.1.1 Self-insured Benefits

For self-insured benefits, the Sponsoring Employer contracts with a third-party

administrator (the “Claims Administrator”) to administer these benefits. Claims for self-insured benefits are paid directly from the general assets of the Employer. The Claims Administrator has full discretion and authority to interpret and administer the Plan, including the final and binding authority to make all determinations related to claims and appeals for self-insured benefits. Benefits under the Plan will be paid only if the Plan Administrator, or its delegate (such as the Claims Administrator), determines in its discretion that the applicant is entitled to them.

5.1.2 Fully-insured Benefits

For fully-insured benefits, the Sponsoring Employer purchases an insurance contract from an insurance company (the “Insurer”). Claims for fully-insured benefits are paid from the Insurer’s assets. Other than questions related to eligibility, the Insurer has full discretion and authority to interpret and administer the Plan, including the final and binding authority to make all determinations related to claims and appeals under a fully-insured option. Benefits under the Plan will be paid only if the Plan Administrator, or its delegate (such as the Insurer), determines in its discretion that the applicant is entitled to them.

The *General Information* section at the end of this SPD describes whether each benefit is self-insured or fully-insured, lists the Claims Administrator or Insurer for each benefit and provides contact information for each Claims Administrator or Insurer. If you have any questions, you should contact the Plan Administrator at the number listed in the *General Information* section at the end of this SPD.

5.1.3 Group Health Plan Claims Procedures (Medical, Dental, Vision, and Health Care Flexible Spending Account Benefits)

Either you or your authorized representative may file claims for medical, dental and vision benefits, including Health Care Flexible Spending Account benefits. If your claim is denied, you or an authorized representative may appeal that denial. An “authorized representative” means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an Urgent Care Claim, a health care professional with knowledge of your condition may act as your authorized representative. All communications from the Plan will be directed to your authorized representative unless your written designation provides otherwise.

Your initial claim should be filed with the applicable Claims Administrator or Insurer listed in the General Information section of this SPD. All claims are treated as filed on the date they are received. If your claim is denied in whole or in part, you will receive a written notice of the denial directly from the Claims Administrator or Insurer. The notice will explain the reason for the denial and the review procedures. The specific requirements applicable to medical and dental claims depend on whether the claim involves an Urgent Care Claim, a Pre-Service Claim, or a Post-Service Claim.

The following group health plan procedures apply to any rescission (as defined under the Patient Protection and Affordable Care Act (PPACA) and guidance thereunder) of coverage that is not attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. You will be provided with 30 days’ advance written notice of any rescission.

If you need assistance with your claim, appeal of a denied claim, or the external review process, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

All claims and appeals under the Plan will be adjudicated in such a manner as to maintain the independence and impartiality of all those involved in making a benefit decision. Decisions regarding the hiring, compensation, termination, promotion, incentives or other similar matters regarding any individual or organization making decisions in the claims and appeals process (such as a claims adjudicator, medical expert, or Independent Review Organization) will not be made based upon the likelihood that the individual or organization will support the denial of benefits.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will continue to provide coverage pending the outcome of an appeal, to the extent required by PPACA, in accordance with the requirements of 29 CFR 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

The following terms are defined for purposes of this Section 5.1.3:

- Plan means, for purposes of this claims procedure, any EOC listed in Appendix A that provides benefits for health care or treatment.
- Claims Reviewer means the person or entity responsible for the relevant claims determination under the Plan.

5.1.4 Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an Urgent Care Claim, you will be notified whether the service, supply or procedure is payable under the Plan as soon as reasonably possible, taking into account the medical exigencies, but no later than 72 hours after the claim is received, either orally or in writing, unless you fail to provide sufficient information necessary to decide a claim. In this situation, the Claimant will be informed within 24 hours after submitting the claim the specific information necessary to complete the claim. Notification may be oral, unless the Claimant requests written notification. The Claimant will be given at least 48 hours to provide the requested information. The Claims Reviewer will notify the Claimant of the benefit determination no later than 48 hours after the earlier of the Plan's receipt of the requested information or the end of the period the Claimant was given to supply the additional information.

In the event the Claimant fails to follow proper Plan procedures in submitting a claim, the Claimant will be notified within 24 hours after the Plan initially receives the claim so that the Claimant can make proper adjustments.

“Urgent Care Claim” means a claim for services received for an illness, injury or condition that could seriously jeopardize your life or health or your ability to regain maximum function or a condition that, in your treating physician’s opinion, could subject you to severe pain that cannot adequately be managed without such care or treatment. The Plan will defer to the attending provider with respect to the decision as to whether a claim is an Urgent Care Claim. The determination of whether a claim involves Urgent Care will be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that a claim shall automatically be treated as an Urgent Care claim if a physician with knowledge of the Claimant’s medical condition determines that the claim involves Urgent Care.

5.1.5 Pre-Service and Post-Service Claims

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, such a claim will be considered a “Pre-Service Claim.” You will be notified of the decision no later than 15 days after receipt of the Pre-Service Claim. All other claims will be deemed to be “Post-Service Claims.” You will be notified of a Post-Service Claim decision no later than 30 days after receipt of such claim.

For Pre-Service Claims, the Claims Reviewer’s initial 15-day response period may be extended by the Plan for up to 15 days, provided that the Claims Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the Claimant with written notification prior to the expiration of the initial 15-day period explaining the reason for the additional extension and when the Plan expects to decide the claim. If the initial 15-day period of time is extended due to the Claimant’s failure to submit information necessary to decide a claim, the written notification will set forth the specific information required and the Claimant will have at least 45 days to provide the requested information. In that case, the Plan’s timeframe for making benefits determination is tolled from the date the Claims Reviewer sends the Claimant an extension notification until the date the Claimant responds to the request for additional information or the Claimant’s time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information is received by the Plan. In the event the Claimant fails to follow proper Plan procedures in submitting a Pre-Service Claim, the Claimant will be notified within five days after the Plan initially receives the claim so that the Claimant can make proper adjustments.

For Post-Service Claims, the Claims Reviewer’s initial 30-day response period may be extended by the Plan for up to 15 days, provided that the Claims Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the Claimant with written notification prior to the expiration of the initial 30-day period explaining the reason for the additional extension and when the Plan expects to decide the claim. If the initial 30-day period of time is extended due to the Claimant’s failure to submit information necessary to decide a claim, the written notification will set forth the specific information required and the Claimant will have at least 45 days to provide the requested information. In that case, the Plan’s timeframe for making a benefit determination is tolled from the date the Claims Reviewer sends the Claimant an extension notification until the date the Claimant responds to the

request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information was received by the Plan.

5.1.6 Ongoing Course of Treatment

In certain situations, the Plan may approve an ongoing course of treatment. For example, treatment provided over a period of time or approval of a certain number of treatments. If the Plan reduces or terminates the course of treatment before its completion, except in the case where the Plan is amended or terminated in its entirety, this shall constitute an adverse benefit determination. The Claims Reviewer will notify the Claimant of this adverse benefit determination within sufficient time to allow the Claimant to appeal the decision and obtain a determination on review before the benefit is reduced or terminated.

If the Claimant requests to extend the course of treatment and the claim involves an Urgent Care situation, the Claims Reviewer will notify the Claimant of the claim determination (whether adverse or not) as soon as possible, but in no case more than 24 hours after the Claimant requests an extension, provided that the Claimant submits such claim at least 24 hours prior to the expiration of the initial treatment period.

5.1.7 Notification of Adverse Claim Determination

If the Claimant's claim for benefits is denied, in whole or in part, the Claimant or the Claimant's authorized representative will receive a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the denial;
- Sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount;
- references to the specific Plan provisions on which the benefit determination was based;
- a description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary;
- A statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
- a description of the Plan's internal appeals procedures, any applicable the external review process, information regarding how to file an appeal, and applicable time

limits, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;

- if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request;
- if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances, or a statement that this will be provided free of charge upon request;
- identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;
- the denial code and its corresponding meaning (if applicable), as well as a description of the Plan's standard, if any, that was used in denying the claim;
- the contact information for the Employee Benefits Security Administration any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act; and
- in the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims.

The notice will also be written in a culturally and linguistically appropriate manner as defined by applicable regulations. The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, upon request as soon as practicable. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

In order to expedite the process in a situation involving an Urgent Care Claim, the Claimant may initially be notified of an adverse claim determination orally, but a written notification providing the information set forth above shall follow within three days.

5.1.7 Filing an Appeal of an Adverse Benefits Determination

In general, the term "adverse benefit determination" includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. For purposes of the Health Benefit, the term "adverse benefit determination" includes a rescission of

coverage, regardless of whether there is a denial, reduction, termination, or failure to provide or make payment for a benefit at that time.

You will have 180 days following receipt of an adverse benefit determination to appeal the decision. The Claimant may submit with this appeal any written comments, documents, records and any other information relating to the claim. Upon request, the Claimant will also have access to, and the right to obtain copies of, all Plan documents, records and information relevant to the claim free of charge. The Claimant is entitled to review the Plan's claim file and to present evidence and testimony in support of his or her claim.

If the situation involves an Urgent Care Claim, the Claimant can request an expedited review process whereby the Claimant may submit the appeal orally or in writing, and all necessary information, including the Plan's benefit determination on review, shall be relayed to the Claimant by telephone, fax, or other similarly expeditious method.

A full review of the information in the claim file and any new information submitted to support the appeal, including all comments, documents, records, and other information will be conducted. The claim determination will be made by the Claims Reviewer of the Plan. The Claims Reviewer will not have been involved in the initial benefit determination nor is the subordinate of the person making the initial determination. This review will not afford any deference to the initial claim determination.

If the initial adverse decision was based in whole or in part on a medical judgment, the Claims Reviewer will consult a healthcare professional who has appropriate training and experience in the relevant field of medicine and who was not consulted in the initial adverse benefit determination and is not a subordinate of the healthcare professional who was consulted in the initial adverse benefit determination. If a healthcare professional is contacted in connection with the appeal, the Claimant will have the right to learn the identity of such individual.

5.1.8 Interim Notification of New Evidence or Rationale during pendency of Internal Appeal

If during the pendency of the claim or appeal the Plan obtains any new or additional evidence that is considered, relied upon, or generated by or at the direction of the Plan in connection with the claim, the Plan will provide the Claimant with the new or additional evidence at no cost as soon as possible and sufficiently in advance of the date when the Plan must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

Additionally, before the Plan denies such a claim on appeal in whole or part based on a new or additional rationale, the Plan will provide the Claimant with the new or additional rationale at no cost as soon as possible and sufficiently in advance of the date when the Claims Reviewer must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

5.1.9 Notification of Final Internal Decision on Appeal

You will be notified of the decision no later than 30 days (for Pre-Service Claims) or 60 days (for Post-Service Claims) after the appeal is received. For Urgent Care Claims, you will be notified as soon as possible, but no more than 72 hours after the appeal is received.

If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the denial;
- Sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount;
- references to the specific Plan provisions on which the benefit determination was based;
- A statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
- a description of any voluntary review procedures, internal appeals and the external review process, including information on how to initiate an appeal and applicable time limits;
- if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request.
- if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances, or a statement that this will be provided free of charge upon request;
- identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;

- the denial code and its corresponding meaning (if applicable), as well as a description of the Plan's standard, if any, that was used in denying the claim;
- a discussion of the decision to deny the claim;
- disclosure of the availability of, and the contact information for, the Employee Benefits Security Administration any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793; and
- a statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA.

The notice will also be written in a culturally and linguistically appropriate manner as defined by applicable regulations. The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, upon request as soon as practicable. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

5.1.10 External Review

The following review procedures apply to non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA. Specifically, they apply to such plans that are self-insured. Fully-insured group health Plans subject to external review requirements are generally subject to applicable state external review procedures, as outlined in each Plan. However, in the event those state external review procedures do not comply with PPACA requirements by the enforcement deadline imposed by the Departments of Labor and Health and Human Services, then such fully-insured Plans will be governed by these procedures to the extent necessary to comply with PPACA.

These procedures are intended to comply with the interim safe harbor contained in U.S. Department of Labor Technical Release 2010-01, as modified by Department of Labor Technical Release 2011-01, Department of Labor Technical Release 2011-02, and 76 Fed. Reg. 37208-37234 (June 24, 2011). At such time that guidance is revised or replaced by the Department, the new guidance shall be incorporated by reference herein and these procedures will be superseded by such new guidance to the extent necessary to comply with PPACA.

A. Standard External Review

This Section 5.1.10.A. describes the procedures for standard external review. Standard external review is external review that is not considered expedited (as described in Section 5.1.10.B., below).

1. **Requests for External Review.** A Claimant may file a request for external review within four months after the date of receipt of a notice of an adverse benefit

determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. Except for requests for external review initiated before September 20, 2011, external review is only available for:

- a. A rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time; and
- b. An adverse benefit determination (including a final adverse benefit determination) that involves medical judgment, as determined by the external reviewer. An adverse benefit determination that involves medical judgment includes, but is not limited to, an adverse benefit determination based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or the Plan's determination that a treatment is experimental or investigational. Additional examples of situations where a claim is considered to involve medical judgment include adverse benefit determinations based on:
 - i. The appropriate health care setting for providing medical care to an individual (such as outpatient versus inpatient care or home care versus rehabilitation facility);
 - ii. Whether treatment by a specialist is medically necessary or appropriate (pursuant to the Plan's standard for medical necessity or appropriateness);
 - iii. Whether treatment involved "emergency care" or "urgent care", affecting coverage or the level of coinsurance;
 - iv. A determination that a medical condition is a preexisting condition;
 - v. The Plan's general exclusion of an item or service, if the Plan covers the item or service in certain circumstances based on a medical condition;
 - vi. Whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under the Plan's wellness program, if any;

- vii. The frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified, in the recommendation or guideline of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (as described in PHS Act section 2713 and its implementing regulations); and
 - viii. Whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques.
- 2. Preliminary Review. Within five (5) business days after the date of receipt of the external review request, the Claims Reviewer will review the request to determine whether:
 - a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
 - b. The adverse benefit determination or the final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility to participate under the terms of the Plan (eligibility claims are not subject to external review);
 - c. The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the final internal appeals process; and
 - d. The Claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Claims Reviewer will issue a written notification to the Claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and the toll-free (if available) contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. The Plan will allow a Claimant to perfect the request for external review within the later of: (a) the four-month filing period, or (b) the 48 hour period after the receipt of notification.

- 3. Referral to Independent Review Organization. The Claims Reviewer will assign an independent review organization (IRO) accredited by a nationally-recognized

accrediting organization to conduct the external review. The Claims Reviewer will contract for assignments under the Plan with at least three IROs. The Plan will rotate claim assignments among the IROs or incorporate other independent, unbiased methods for selection of IROs, such as random selection. The contract between the Plan and an IRO will provide the following:

- a. The IRO will use legal experts where appropriate to make coverage determinations under the Plan.
- b. The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten (10) business days after the date of receipt of the notice that the IRO must consider when conducting external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.
- c. Within five (5) business days after the date of assignment of the IRO, the Plan will provide the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan does not timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making such a decision, the IRO must notify the Claimant and the Plan.
- d. Upon receipt of any information submitted by the Claimant, the IRO must within one (1) business day forward the information to the Plan. The Claims Reviewer may, but is not required to, reconsider its adverse benefit determination or final internal adverse benefit determination. Reconsideration by the Plan will not delay the external review. If the Claims Reviewer decides to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment, the Claims Reviewer will provide written notice of its decision to the Claimant and the IRO within one (1) business day after making its decision. The IRO will terminate the external review upon receiving this notice from the Claims Reviewer.
- e. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will

consider the following in reaching a decision:

- i. The Claimant's medical records;
 - ii. The attending health care professional's recommendation;
 - iii. Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, Claimant, or the Claimant's treating provider;
 - iv. The terms of the Plan to ensure that the IRO's decision is not contrary to the Plan's terms, unless the terms are inconsistent with applicable law;
 - v. Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - vi. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the Plan's terms or with applicable law; and
 - vii. The opinion of the IRO's clinical reviewer or reviewers after considering the available information or documents to the extent the clinical reviewer or reviewers consider appropriate.
- f. The IRO will provide written notice to the Claimant and the Plan of the final external review decision within 45 days after the IRO receives the request for the external review. The notice will contain:
- i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, and if applicable, the claim amount, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - ii. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - iii. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision;
 - iv. A discussion of the principal reason or reasons for its decision,

including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

- v. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the Claimant;
 - vi. A statement that judicial review may be available to the Claimant; and
 - vii. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.
4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The final external review decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

B. Expedited External Review

1. Request for Expedited External Review. When external review is otherwise available, the Plan will allow a Claimant to make a request for an expedited external review at the time the Claimant receives:
 - a. An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal, or
 - b. A final internal adverse benefit determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum

function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant receive emergency services, but has not been discharged from a facility.

2. Preliminary Review. Immediately upon receipt of the request for expedited external review, the Claims Reviewer will review the request to determine whether the request meets the reviewability requirements described in Section II.A.2. above for Standard External Review. The Plan must immediately send a notice that meets the requirements set forth in Section II.A.2. for Standard External Review to the Claimant of its eligibility determination.
3. Referral to Independent Review Organization. Upon determination that a request is eligible for expedited external review following preliminary review described in Section II.B.2. above, the Claims Reviewer will assign an independent review organization (IRO) in accordance with the requirements described in Section II.A.3. above for Standard External Review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefits determination to the assigned IRO electronically or by telephone or fax or any other available expeditious method.

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

4. Notice of Final External Review Decision. The IRO will provide written notice to the Claimant and the Plan of the final external review decision, in accordance with the requirements of Section II.A.3.f. above for Standard External Review, except that the notice will be provided as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, then within 48 hours after the date of providing that notice, the IRO must provide written confirmation of that decision to the Claimant and the Plan.
5. Reversal of Plan's decision.

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The final external review decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the

claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

C. IRO Recordkeeping Requirements

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

5.1.11 Disability Plan Claims Procedures

If the Claimant submits a claim for disability benefits provided under an insurance policy or any other contract for disability benefits administered by an outside provider, the claims and appeals procedures set forth in the insurer's or other third-party administrator's policy or contract must be followed. If the disability Program is administered by the Employer or if an outside provider has failed to establish a claims and appeals procedure, the following procedures must be followed:

A. Determination of Benefits

For the purposes of this disability benefit claims procedure, the term Claims Reviewer means the person or entity responsible for the relevant determination under a disability Program and the term Plan means any Program that provides benefits in the event of a disability. The Claims Reviewer will notify the Claimant of the claim determination within 45 days of the receipt of the claim. This period may be extended by 30 days if an extension is necessary to process the claim due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and when the Plan expects to decide the claim, will be furnished to the Claimant within the initial 45-day period. This period may be extended for an additional 30 days beyond the original extension. A written notice of the additional extension, the reason for the additional extension and when the Plan expects to decide the claim, will be furnished within the first 30-day extension period if an additional extension of time is needed. All notices of extension will 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, and that the Claimant will have at least 45 days to provide the requested information. If a period of time is extended due to the Claimant's failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Reviewer will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information received by the Plan.

B. Notification of Adverse Claim Determination

If the claim for benefits is denied, in whole or in part, the Claimant will receive a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

1. the specific reason(s) for the denial;
2. references to the specific Plan provisions on which the benefit determination was based;
3. a description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary;
4. a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
5. a description of the Plan's appeals procedures and applicable time limits, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;
6. a discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following:
 - i. the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;
 - ii. the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - iii. the Claimant's disability determination by the Social Security Administration that the Claimant presented to the Plan;
7. either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim or, alternatively, a statement that these sorts of rules, guidelines, protocols, standards or criteria of the Plan do not exist; and
8. if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances; or a statement that this will be provided free of charge upon request.

C. Appeal of Adverse Determination

If a claim for benefits is denied, the Claimant may appeal the denied claim in writing to the Claims Reviewer within 180 days of the receipt of the written notice of denial. The Claimant may submit with the appeal any written comments, documents, records and any other information relating to the claim. Upon request, the Claimant will also have access to, and the right to obtain copies of, all Plan documents, records and information relevant the claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted. The claim determination will be made by the Claims Reviewer of the Plan. The Claims Reviewer will not have been involved in the initial benefit determination nor will the Claims Reviewer be the subordinate of any individual involved in the initial claim for benefits. This review will not afford any deference to the initial claim determination.

If the initial adverse decision was based in whole or in part on a medical judgment, the Claims Reviewer will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment, was not consulted in the initial adverse benefit determination and is not a subordinate of the healthcare professional who was consulted in the initial adverse benefit determination.

D. Notification of Decision on Appeal

The Claims Reviewer will make a determination on the appeal within 45 days of the receipt of the appeal request. This period may be extended for an additional 45 days if the Claims Reviewer determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Claims Reviewer expects to render a decision will be furnished to the Claimant within the initial 45-day period. However, if the period of time is extended due to the Claimant's failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which the Claimant responds to the request for additional information.

In connection with the appeal, a Claimant may submit written comments, documents, records, and other information relating to the claim. In addition, the Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The review of the appeal will take into account all comments, documents, records, and other information that the Claimant submits, whether or not the Claimant first raised the issues or first submitted that information when the claim was originally considered.

The claim will be reviewed independently of the original claim and will be conducted by a named fiduciary of the Plan other than the Claims Reviewer.

In deciding an appeal of a claim denial that is based in whole or in part on a medical

judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not be the same person who was consulted in connection with the original claim or any of his or her employees.

The Claims Reviewer will provide the Claimant with the name(s) of the health care professional(s) who was/were consulted in connection with the original claim, even if the claim denial was not based on his/her/their advice.

Before the Plan can deny the Claimant's appeal, the Claims Reviewer will provide the Claimant, free of charge, with:

- Any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; and
- Any new or additional rationale on which the denial of the appeal will be based.

This evidence and rationale will be provided as soon as possible and sufficiently in advance of the expiration of the 45-day period discussed above in order to give the Claimant a reasonable opportunity to respond prior to that date.

If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a culturally and linguistically appropriate manner calculated to be understood by the Claimant and will include:

1. the specific reason(s) for the adverse determination;
2. references to the specific Plan provisions on which the determination was based;
3. a statement that the Claimant is entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to the Claimant's benefit claim upon request;
4. a description of any voluntary review procedures and applicable time limits, the Claimant's right to obtain the information about those procedures, a statement of the Claimant's right to bring an action under Section 502(a) of ERISA, and a description of any applicable contractual limitations period that applies to the Claimant's right to bring the action, including the calendar date on which the contractual limitations period expires for the claim;
5. a discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following;
 - a. the views presented by the Claimant to the Plan of health care professionals

- treating the Claimant and vocational professionals who evaluated the Claimant;
 - b. the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - c. the Claimant's disability determination by the Social Security Administration that the Claimant presented to the Plan;
6. either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim on appeal or, alternatively, a statement that those sorts of rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
 7. if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances, or a statement that an explanation will be provided free of charge upon request.

5.1.12 Life Insurance, AD&D, Long-Term Care, and Business Travel Accident Benefits

You, your beneficiary or an authorized representative may file claims for life insurance (basic life, optional life, or dependent life), accidental death and dismemberment insurance (AD&D) (basic and supplemental), long-term care insurance, or business travel benefits. If your claim is denied, you, your beneficiary or an authorized representative may appeal that denial. An "authorized representative" is a person you authorize in writing to act on your behalf. All communications from the Plan will be directed to your authorized representative unless your written designation provides otherwise.

If the claim is denied, the Claims Administrator or Insurer will notify the claimant of such denial in writing within 90 days, or within 180 days if the Claims Administrator or Insurer notifies the claimant in writing that special circumstances require additional time for processing the claim. The notice will (i) explain the reason for the denial, (ii) refer to the pertinent Plan provisions on which the denial is based, (iii) describe any additional material necessary to perfect the claim and explain why such material is necessary, and (iv) explain the steps to be taken if the claimant wishes to submit the claim for review.

A claimant (or his or her duly authorized representative) may appeal the denial of a claim by filing a written appeal with the Claims Administrator or Insurer within 60 days of the original denial. The appeal must contain (i) the date on which the original claim was filed, (ii) the specific portions of the denial the claimant wishes the Claims Administrator or Insurer to review, (iii) a statement setting forth the reasons the denial should be reversed, and (iv) any written

material the claimant wishes the Claims Administrator or Insurer to examine when reconsidering the claim. The Claims Administrator or Insurer will permit the claimant to examine any documents that are relevant to his or her claim.

The Appeals Administrator will notify the claimant of its decision on the appeal in writing within 60 days, or within 120 days if the Claims Administrator or Insurer notifies the claimant in writing that special circumstances require additional time for reviewing the appeal. The Claims Administrator's or Insurer's final written decision will include specific reasons for the decision, specific references to the pertinent Plan provisions on which the decision is based, and an explanation of your rights under ERISA's claims and appeals rules. Any such decision will be final and binding.

After receiving a final appeal decision, the claimant will have exhausted his or her administrative remedies under the Plan, and will have a right to bring an action for benefits under ERISA Section 502(a)(1)(B). Benefits will be paid under the Plan only if the Claims Administrator or Insurer determines in its discretion that the claimant is entitled to them.

If any judicial or administrative proceeding is undertaken, the evidence presented will be strictly limited to the evidence timely presented to the designated Claims Administrator.

5.1.13 Statute of Limitations and Exhaustion of Administrative Remedies

All claims for benefits must be submitted by the claims filing deadline specified under the rules for a particular EOC. If the EOC does not specify a filing deadline, then claims must be submitted within 120 days of the final decision on appeal by the Claims Reviewer. This requirement may be waived by the Plan if, through no fault of the Participant or Beneficiary, the claim is filed after the deadline but is filed as soon as practicable and within a reasonable time period, given the particular circumstances.

The Claimant may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Claims Reviewer, the Plan Sponsor, or any other person, with respect to a claim for disability, medical, or other claims for benefits without first exhausting the claims procedures set forth above. A Claimant who has exhausted these procedures and is dissatisfied with the decision on appeal of a denied claim may bring an action under Section 502 of ERISA in an appropriate court to review the Claims Reviewer's or Plan Administrator's decision on appeal, but only if such action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the decision on appeal.

A. Failure to Follow the Claims Procedure for Health Plan Claims or Rescissions of Health Plan Coverage

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, then notwithstanding the previous paragraph, if the Plan fails to adhere to all of the requirements of the procedures set forth above for health Plan claims or rescissions of health Plan coverage, then to the extent mandated by PPACA, the Claimant may initiate an external review or bring an action in an appropriate court under state law or section

502(a) of ERISA, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the Claims Reviewer's decision on appeal. However, the Claimant cannot initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA without first exhausting the claims procedures set forth above if the violation by the Plan was:

1. *De minimis*;
2. Not likely to cause, prejudice or harm to the Claimant;
3. Attributable to good cause or matters beyond the Plan's control;
4. In the context of an ongoing good-faith exchange of information; and
5. Not reflective of a pattern or practice of non-compliance by the Plan.

Within 10 days of the Plan's receipt of a written request by the Claimant, a Claimant is entitled to an explanation of the Plan's basis for asserting that it meets the above exception that includes a specific description of its bases, if any, for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the requirements for the exception, then the Plan will provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim within a reasonable time after the external reviewer or court rejected the claim for immediate review (but not to exceed ten days). Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

B. Failure to Follow the Claims Procedure for Disability Benefits Claims

Notwithstanding the above, if the Plan fails to strictly adhere to the claims procedures for disability benefits claims, the Claimant will be deemed to have "exhausted" all administrative remedies available under the Plan. The Claimant will then be entitled to bring an action under Section 502(a) of ERISA on the basis that the Plan failed to provide the Claimant with a reasonable claims procedure that would yield a decision on the merits of the Claimant's claim. If the Claimant chooses to bring an action under Section 502(a) of ERISA in these circumstances, the Claimant's claim or the Claimant's appeal of the Claimant's claim denial will be deemed to have been denied by the Plan on review.

Notwithstanding the above paragraph, the administrative remedies available under the Plan will not be deemed to have been "exhausted" based on minor violations that do not cause and are not likely to cause the Claimant to be prejudiced or harmed in any way, provided the Plan shows that the violation was for a good cause or due to matters beyond its control, and that the violation occurred in the context of an ongoing, good faith exchange of information between the Claimant and the Plan. This exception is not available to the Plan if the violation is part of a pattern or practice of violations by the Plan.

The Claimant may request a written explanation of the violation from the Plan. The Plan must provide the requested explanation within 10 days, including a specific description of the bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted.

If a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception, the claim will be considered to be re-filed on appeal upon the Plan's receipt of the decision of the court. The Plan will provide a notice of the resubmission to the Claimant within a reasonable time after the receipt of the decision.

5.1.11 Special Appeal Rules Applied by Insurers

When you exhaust the Plan's claim and appeal procedures, some Insurers might have additional appeal rules that require binding arbitration, that limit your rights to go to court or that require you to submit your appeal to an "independent reviewer." These appeal rules do not always comply with ERISA. The following is a list of Insurer procedures that do not comply with ERISA. If you have reached a level of appeal that requires you to do one of the following, you should know that the procedures described above and the rules in the *ERISA Rights* section of this SPD will override the Insurer's requirements.

No Insurer may require you to do any of the following:

- No Insurer may require you to submit to binding arbitration or to binding mediation. If your EOC advises that you must submit to binding arbitration or binding mediation after you exhaust the Insurer's internal grievance procedures you should know this rule does not comply with ERISA. If you voluntarily agree to binding arbitration or binding mediation, you may be giving up the right you have under ERISA to sue the Insurer in federal court. If you have a serious claim, you should check with legal counsel before you submit to binding arbitration or binding mediation with the Insurer.
- No Insurer can make the statement that by virtue of becoming covered under the insurance policy, you have agreed to give up any rights you have to sue, including any "constitutional rights" or any "ERISA rights."
- No Insurer may require you to pay for any internal grievance or appeal procedure. If the EOC tells you that you must pay for part or all of any type of fees involved in a grievance procedure, arbitration, mediation, or any legal fees, you should know that ERISA does not allow this type of charge.
- No Insurer may require you to undergo more than two levels of appeal following the initial denial of your claim for benefits. If your Insurer has additional levels of appeals, you may choose to follow those optional appeal procedures rather than to sue the Insurer in federal court under ERISA. However, by submitting to these additional appeals procedures, you may negatively affect your ability to sue the Insurer under ERISA (for example, if the Insurer is required under state law to

provide additional levels of review, then the statute of limitations on your claim may continue to run while you pursue your appeal with the Insurer). If you have a serious claim, you should check with legal counsel before you choose to pursue optional Insurer appeals rather than taking your case directly to federal court.

- No Insurer may require that you accept the decision of an independent reviewer on an appeal of a denied claim. The Insurer may be required to submit your claim to an independent reviewer under state law, and you can agree to abide by the independent reviewer's decision if you want to do so. However, before you agree ahead of time to accept the decision of an independent reviewer, make certain you read the *ERISA Rights* section of this SPD, because you may be giving up your right to sue for the benefit under ERISA.
- If you find that you want to exercise the rights described in the *ERISA Rights* section of this SPD, you should not wait too long after the Insurer gives you its final decision when you go through the grievance procedure. This is because, depending on the length of time that has gone by since you first requested the insurance benefit, there may be a time limit on your ability to take action under *ERISA Rights*.

All Insurers are subject to state regulations. If you have a complaint about an Insurer you can contact the state insurance department listed in your EOC. Remember, even when you contact the state insurance department with a complaint, you still have ERISA rights as explained in the ERISA Rights section of this SPD.

ARTICLE VI

Plan Administration; Amendment and Termination

6.1 Plan Administration

The Sponsoring Employer's Pension and Savings Committee (the "Committee") is responsible for the general administration of the Plan and is the "Named Fiduciary" and "Plan Administrator" of the Plan for purposes of ERISA. The Committee has the discretionary authority to delegate fiduciary functions to other entities, including Insurers and third-party administrators. The Committee has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions, and such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and the Committee will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Insurers, third-party administrators, the Committee, nor the Employer will be liable in any manner for any determination made in good faith.

The Committee has designated several Claims Administrators and Insurers, and may designate other organizations or persons, to carry out specific fiduciary responsibilities of the Committee in administering the Plan including, but not limited to, the following:

- pursuant to an administrative service or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping,
- the responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan, and
- the responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an Insurer or administrator is not empowered with such responsibility.

The Committee will administer the Plan on a reasonable and nondiscriminatory basis and will apply uniform rules to all persons similarly situated.

The Health Benefit (medical and prescription drug coverage), Health Care Flexible Spending Account, and some short-term disability benefits are self-insured by the Employer. This means that these benefits are paid directly out of the general assets of the Employer. There is no special fund or trust from which benefits are paid. The Sponsoring Employer has engaged the services of third-party administrators (noted below in the *General Information* section of the SPD) who are responsible for processing claims for these self-insured benefits.

6.2 Power and Authority of the Insurers

In certain cases, benefits are provided under a group insurance contract entered into between the Sponsoring Employer and an Insurer. With respect to fully-insured benefits, claims for benefits are sent to the Insurer, and the Insurer is responsible for paying claims, not the Employer.

The Insurer is responsible for:

- determining eligibility for and the amount of any benefits payable under the Plan; and
- prescribing claim procedures to be followed and the claim forms to be used by employees pursuant to the Plan.

The Insurer also has the authority to require employees to furnish it with such information as it determines is necessary for the proper administration of the Plan.

The dental, vision, long-term disability, life insurance (basic, optional, and dependent), AD&D insurance (basic and supplemental), hospital care, critical illness, long-term care

insurance, business travel accident insurance and some short-term disability benefits are fully insured through contracts with Insurers (noted in the *General Information* section at the end of the SPD). The Insurers administer claims for these benefits and are solely responsible for providing benefits.

6.3 Books and Records

The Administrator shall keep such books, records and other data as it deems necessary for proper administration of the Plan. The records of the Administrator shall be binding on all persons unless proved incorrect to the satisfaction of the Administrator. The Administrator shall make available to each Participant, Eligible Employee and any other employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

6.4 Indemnification

Any Employee of the Employer acting in any capacity under the provisions of this Plan shall be indemnified and held harmless by the Employer from and against any liability, including without limitation attorney's fees reasonably incurred, to which he or she may be subjected by reason of any act done or omitted in connection with the administration of the Plan except in the case of his or her own gross negligence or intentional misconduct.

6.5 Amendment and Termination

Any amendment, termination or other action by the Sponsoring Employer with respect to the Plan shall be by a duly adopted resolution of the Board of Directors or delegated to a committee or persons authorized to take such action on behalf of the Board. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of the Sponsoring Employer, the Plan shall terminate unless the Plan is continued by a successor to the Sponsoring Employer.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to the Sponsoring Employer to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document.

ARTICLE VII

COBRA Rights

7.1 COBRA Rights

7.1.1 COBRA Generally

Federal law requires most employers sponsoring group health plans to offer certain individuals (called “Qualified Beneficiaries”) the right to continue their health coverage for a limited period of time in certain instances (called “Qualifying Events”) where coverage under the Plan would otherwise end. This right is called “COBRA” continuation coverage. The following information is intended to inform you of your COBRA rights and obligations.

Benefits provided to Children, Dependents, and Non-Tax Dependents who are not qualified beneficiaries for COBRA purposes (e.g., a domestic partner and/or the children of the domestic partner), may be extended through continuation coverage in accordance with the Sponsoring Employer’s policies upon loss of benefits under the Plan as a result of a change in the domestic partner status.

7.1.2 Qualified Beneficiaries

Any Participant, spouse of the Participant, or Child of the Participant, who is covered by the Plan on the day before a Qualifying Event is a Qualified Beneficiary. A child born to or placed for adoption with a former employee who is a Qualified Beneficiary during a period of COBRA continuation coverage is a Qualified Beneficiary. These newly-added children are allowed to continue COBRA coverage for the remainder of the period of coverage available to the former employee/Qualified Beneficiary.

Each Qualified Beneficiary has a separate right to elect COBRA coverage. For example, the spouse may elect COBRA coverage even if the covered employee does not. COBRA coverage may be elected for only one, several, or for all Children who are Qualified Beneficiaries. A parent may elect COBRA coverage on behalf of any Children. The covered employee or the employee’s spouse can elect continuation coverage on behalf of all the Qualified Beneficiaries.

7.1.3 Qualifying Events

To be eligible for COBRA continuation coverage, a Qualified Beneficiary must lose coverage under the Plan on account of a Qualifying Event, as follows:

(a) Employees. If you are an Employee and covered by the Plan, you have the right to elect COBRA continuation coverage if you lose group health coverage under the Plan because of a reduction in your hours of employment (including your failure to return to work after a leave taken under the Federal Family and Medical Leave Act) or because your employment is terminated for reasons other than gross misconduct.

(b) Spouses. If you are the spouse of an Employee and you are covered by the Plan, you have the right to elect COBRA continuation coverage for yourself if you lose group health coverage under the Plan for *any* of the following four reasons:

- The death of your spouse;
- A termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment with the Employer (including the employee's failure to return to work after a leave taken under the Federal Family and Medical Leave Act);
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to (that is, covered by) Medicare and revokes coverage under the Plan.

(c) Children. In the case of an employee's Child who is covered under the Plan, he or she has the right to elect COBRA continuation coverage if group health coverage under the Plan is lost for *any* of the following five reasons:

- The death of the employee;
- The termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment with the Employer (including the employee's failure to return to work after a leave taken under the Federal Family and Medical Leave Act);
- The employee's divorce or legal separation;
- The employee becomes entitled to (that is, covered by) Medicare and revokes coverage under the Plan; or
- The Child ceases to be eligible under the Plan (e.g. attains age 26).

7.1.4 Your Responsibility to Notify the COBRA Administrator

You or your Child or Dependent must notify Human Resources and the COBRA Administrator in the event of (i) divorce or legal separation from your spouse or (ii) your Child's ceasing to be eligible under the Plan. To inform the COBRA Administrator of these Qualifying Events, you may be required to complete a Qualifying Event form. To be eligible for COBRA coverage, the COBRA Administrator must receive notice of the Qualifying Event within 60 days of the Qualifying Event. Please note that you will have no right to elect COBRA continuation coverage if you have not notified the COBRA Administrator of the Qualifying Event within 60 days of the Qualifying Event and completed any required forms before such date. You are not required to notify the COBRA Administrator of other Qualifying Events, such as the employee's death, termination, reduction in hours of employment, or Medicare entitlement.

7.1.5 COBRA Election Notice

When the COBRA Administrator is notified that a Qualifying Event has occurred, the COBRA Administrator will provide the Qualified Beneficiary with a COBRA election notice. To elect COBRA continuation coverage, a Qualified Beneficiary must complete and sign the COBRA election notice and return the notice to the COBRA Administrator by first-class mail, or other reliable means of delivery, including personal delivery, express mail within the later of 60 days after the date of the notice, or 60 days after the date the Qualified Beneficiary's health coverage otherwise ends. Please note that you will have no right to elect COBRA continuation coverage if the COBRA election notice is not sent to the Plan Administrator within 60 days of the Qualifying Event. If a former employee elects COBRA continuation coverage, the election will be deemed to include covered dependents unless the employee asks that it not include them. If an Employee's former spouse elects COBRA continuation coverage, the former spouse may elect to include covered dependents who live with the former spouse.

7.1.6 Payments for COBRA Continuation Coverage

A Qualified Beneficiary who elects COBRA continuation coverage must pay for that coverage. Employees receiving severance pay may make pre-tax deductions from their severance pay to pay the applicable COBRA premiums. Premiums for the initial period of COBRA continuation coverage (the period that begins on the date of the Qualifying Event through the date a Qualified Beneficiary elects COBRA continuation coverage) must be made and received by the Plan Administrator within 45 days after the day on which the Qualified Beneficiary elected COBRA continuation coverage. Premiums for subsequent months are due on the first day each month (i.e., payment for coverage for the month of January is due on January 1). However, there is a grace period of 30 days following the due date. The covered person's monthly premium must be received by the Plan Administrator within 30 days after the first of each month. If the Qualified Beneficiary fails to pay the required premium by the end of the 30-day grace period, then COBRA continuation coverage will be terminated retroactively to the end of the last month for which payment has been made (for example, if you fail to pay the premium for the month of January by January 30, then your coverage will be terminated retroactively to December 31). The premium charged for COBRA continuation coverage will be not in excess of 102% of the applicable premium charged by the Plan or, for Social Security disability extensions beyond 18 months (described below), not in excess of 150% of the applicable premium. Premiums for COBRA continuation coverage are changed annually, and you will be notified of any premium changes.

7.1.7 Type Of Coverage

Generally, COBRA continuation coverage is identical to the coverage provided under the Plan to similarly situated employees or family members. Your COBRA continuation coverage may be changed or modified if the coverage provided under the Plan to Employees or family members is changed. You will continue to have open enrollment rights under the Plan for the duration of your COBRA continuation coverage.

7.1.8 Maximum Duration Of COBRA Continuation Coverage

For Health Care Flexible Spending Account Coverage, the law provides that the COBRA continuation period ends on the last day of the Plan year in which the Qualifying Event occurs. For medical, dental and vision coverage, the law provides that the maximum COBRA continuation coverage period is 36 months unless your Qualifying Event is a termination or reduction in hours of employment. In that case, the maximum COBRA continuation coverage period is generally 18 months. There are two ways in which the 18-month period of COBRA continuation coverage can be extended.

7.1.9 Extension for Second Qualifying Events

The 18-month period may be extended to 36 months if a second Qualifying Event occurs during the original 18-month period of COBRA continuation coverage and the affected family member notifies the COBRA Administrator within 60 days of the second Qualifying Event. To inform the COBRA Administrator of a second Qualifying Event, you must obtain a Qualifying Event form from the COBRA Administrator, complete and sign the form, and return the form to the COBRA Administrator within 60 days of the second Qualifying Event by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company. Examples of second Qualifying Events include the employee's divorce or legal separation, a child ceasing to be a "dependent child," the employee becoming entitled to Medicare and revoking coverage under the Plan, or the employee's death. In no event will COBRA continuation coverage last beyond 36 months from the date of the Qualifying Event that originally made an individual eligible to elect coverage.

7.1.10 Extension for Disability Determinations

The 18-month period may also be extended to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security purposes) at any time during the first 60 days of COBRA continuation coverage and the individual notifies the COBRA Administrator within 60 days of the date of the disability determination by the Social Security Administration and before the end of the original 18-month period of COBRA continuation coverage. To inform the COBRA Administrator of the disability determination, you must obtain a Qualifying Event form from the COBRA Administrator, complete and sign the form, and return the form to the COBRA Administrator within 60 days of the determination of disability and before the end of the 18-month period by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company. If the individual entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, these non-disabled family members are also entitled to the extension of the COBRA continuation coverage period from 18 to 29 months. A greater premium amount applies to the 11-month extension period, as explained above. The affected individual(s) also must notify the COBRA Administrator within 30 days of any final determination by the Social Security Administration that the individual is no longer disabled. To inform the COBRA Administrator of a final determination that the individual is no longer disabled, you must obtain a Qualifying Event form from the COBRA Administrator, complete and sign the form, and return the form to the COBRA Administrator by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company. This 29-month period may be extended to 36 months for certain family members if a second Qualifying Event (as explained above) occurs

during the original 29-month period and the affected family member notifies the Plan Administrator within 60 days of the second Qualifying Event.

Please note that you will have no right to extend COBRA continuation coverage (either based on a second Qualifying Event or based on disability) if the appropriate notice is not sent to the COBRA Administrator within the time periods described above.

7.1.11 Termination Of COBRA Continuation Coverage

COBRA continuation coverage under the Plan will end on the first of these dates:

- The end of the 18, 29, or 36-month COBRA continuation coverage period;
- The end of the last month for which the Qualified Beneficiary has properly paid the required premium for COBRA continuation coverage. Late payments (after the 30-day grace period) will not be accepted;
- The date the Plan terminates;
- The first date, after the date you make your COBRA election, on which you become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have. If the exclusions or limitations for pre-existing conditions in the other group health plan would not apply to you (or would be satisfied by you) due to the requirements enacted by the Health Insurance Portability and Accountability Act of 1996, then the Plan may terminate your COBRA continuation coverage;
- The first date, after the date you make your COBRA election, on which you become entitled to Medicare;
- If a disability extension applies, the date of a final determination by the Social Security Administration that the individual is no longer disabled. The disabled individual must notify the Plan Administrator within 30 days of such a determination; or
- The date the Qualified Beneficiary commits fraud or deception in the use of Plan services.

7.1.12 Conversion Option

If your health coverage is provided by an insurance carrier, you may be eligible to enroll in an individual health policy at the end of your COBRA continuation coverage.

7.1.13 Keep Your Plan Informed of Address Changes

To protect your family's rights to COBRA continuation coverage, you should keep the

COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

7.1.14 COBRA Administrator

All notices and communications regarding COBRA continuation coverage should be sent to:

Sentinel Financial Group
55 Walkers Brook Drive, Suite 100
P.O. Box 5000
Reading, MA 01867

ARTICLE VIII

HIPAA Privacy and Security Rules

8.1 Permitted Use and Disclosures of Protected Health Information

The Plan will use and/or disclose protected health information (“PHI”) to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto (“HIPAA”), which are hereby incorporated by reference. For example, the Plan may use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

The following terms are defined for purposes of this subsection:

Protected Health Information (“PHI”) is individually identifiable health information, whether oral or recorded in any form or medium, which is collected from an individual, and which;

- is created or received by the Plan;
- relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
 - a. that identifies the individual; or,
 - b. with respect to which there is a reasonable basis to believe that the information can be used to identify the individual; and,
- is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium. PHI excludes information in education records covered by the Family Educational Right and

Privacy Act, records described at 20 U.S.C. § 1232(g)(a)(4)(B)(iv), and employment records held by the Sponsoring Employer in its role as employer.

Electronic Protected Health Information (“e-PHI”) is PHI that is transmitted by electronic media or maintained in any electronic medium.

Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; and the referral of a patient for health care from one health care provider to another.

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

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual’s claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- risk adjusting amounts due based on enrollee health status (not including genetic information) and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including precertification, preauthorization, concurrent review and retrospective review; and,

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

Health Care Operations include, but are not limited to, the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- underwriting, premium rating and other activities that do not involve consideration of genetic information relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- business management and general administrative activities of the Plan, including, but not limited to:
 - a. management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or,
 - b. customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
- resolution of internal grievances;
- the sale, transfer, merger, or consolidation of all or part of the "covered entity" within the meaning of HIPAA with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and,

- consistent with the applicable requirements of the regulations issued under HIPAA, creating de-identified health information or a limited data set, and fundraising for the benefit of the "covered entity" within the meaning of HIPAA.

Summary Health Information is information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and (2) from which the information described at 45 C.F.R. §164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

Unsecured PHI is PHI that is not secured through the use of technology or methodology specified by the Secretary of Health and Human Services.

B. The Plan Will Use and Disclose PHI Consistent with HIPAA's Requirements and as Permitted by Authorization of the Plan Participant or beneficiary

The Plan will use and disclose PHI consistent with the rules and requirements under HIPAA. To the extent required by HIPAA, the Plan shall obtain a written authorization from the individual who is the subject of the PHI for certain uses and disclosures of PHI.

C. Disclosures to the Sponsoring Employer

The Plan will not disclose PHI to the Sponsoring Employer unless it receives a certification from the Sponsoring Employer that the Plan documents have been amended to incorporate the provisions set forth in D and E, below. Notwithstanding the foregoing, the Plan may disclose to the Sponsoring Employer the following:

1. The Plan may disclose Summary Health Information to the Sponsoring Employer, if the Sponsoring Employer requests the summary health information for the purpose of:

- a. Obtaining premium bids from health plans for providing health insurance coverage under the group health plan; or
- b. Modifying, amending, or terminating the group health plan.

2. The Plan may disclose to the Sponsoring Employer information on whether an individual is participating in the group health plan, or is enrolled in or has disenrolled from a particular coverage option offered by the Plan.

D. Sponsoring Employer Covenants Regarding PHI

The Sponsoring Employer agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;

- ensure that any agents, including a subcontractor, to whom the Sponsoring Employer provides PHI agree to the same restrictions and conditions that apply to the Sponsoring Employer through a written contractual agreement in accordance with 45 CFR § 164.314;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Sponsoring Employer unless authorized by an individual;
- not use or disclose genetic information for underwriting purposes;
- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware, including breaches of Unsecured PHI as required by 45 CFR §164.410, and any other Security Incident of which it becomes aware;
- make PHI available in paper and/or electronic format to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Secretary of Health and Human Services, upon request, for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Sponsoring Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

E. With Respect to e-PHI, the Sponsoring Employer Agrees to the Following Conditions

The Sponsoring Employer agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI that it creates, receives, maintains, or transmits on behalf of the Plan, in accordance with HIPAA security rules;

- Ensure that the adequate separation between the Plan and Sponsoring Employer is supported by reasonable and appropriate security measures;
- 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 as part of its a written contractual agreement in accordance with 45 CFR § 164.314;
- Report to the Plan any Security Incident of which it becomes aware. For purposes of this section, Security Incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI, as well as any probable compromise of Unsecured PHI of which it becomes aware; and,
- Upon request from the Plan, Sponsoring 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 Sponsoring Employer.
- Notwithstanding the foregoing, these limitations shall not apply to Enrollment, Disenrollment, and Summary Health Information provided to Sponsoring Employer pursuant to 45 C.F.R. § 164.504(f)(1)(ii) or (iii); of Electronic PHI released pursuant to an Authorization that complies with 45 C.F.R. § 164.508; or in other circumstances as permitted by the HIPAA regulations.

F. Adequate Separation Between the Plan and the Sponsoring Employer Must Be Maintained

The Sponsoring Employer shall permit only those individuals listed below to have access to PHI in order to carry out their duties with respect to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. In the event that the individuals listed below do not comply with this Plan document, the Sponsoring Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. The Sponsoring Employer will ensure that the adequate separation between the Plan and Sponsoring Employer is supported by reasonable and appropriate security measures.

The following employees, classes of employees or other persons under the Sponsoring Employer's control (or acting on behalf of Sponsoring Employer) may have access to PHI:

- Chief People Officer, who shall also act as the Plan's Privacy Officer;
- Staff of the Human Resources Department; and
- other persons designated by the Privacy Officer or Plan.

G. Limitations of PHI Access and Disclosure

The persons described in Section F may only have access to and use and disclose PHI to the extent necessary to perform plan administration functions that the Sponsoring Employer performs for the Plan.

H. Noncompliance Issues

If the persons described in Section F do not comply with the HIPAA's and the Plan's privacy rules, the Sponsoring Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

I. Participant Notice

The Plan shall be operated in accordance with the Notice of Privacy Practices, written in accordance with 45 CFR § 164.502, which shall be distributed to Plan Participants and which may be amended from time to time by the Plan Administrator or insurer providing benefits.

J. Health Plan Policies and Procedures

In addition to the policies and procedures set forth in the Participant Notice, the Plan has established the policies and procedures to safeguard the privacy of PHI and comply with HIPAA's requirements. The Plan Administrator may amend such policies and procedures from time to time, as it deems appropriate.

K. "Hands-Off" Election

The Sponsoring Employer has elected to be "hands-off" with respect to PHI (as that term is commonly used in the context of HIPAA compliance) for insured group health plan benefits. As such, the Sponsoring Employer and its Employees generally shall not have access to PHI for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Sponsoring Employer on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Sponsoring Employer in connection with any other benefits or benefit plan of the Sponsoring Employer or any employment-related actions or decisions. However, the Sponsoring Employer and its Employees shall have access to the following:

(i) Enrollment and disenrollment information - On behalf of the Plan, the Plan Administrator may disclose to the Sponsoring Employer information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a Program or Program component offered by the Plan. Enrollment and disenrollment functions performed by Sponsoring Employer are performed on behalf of Plan Participants and their covered dependents, and are not Plan administration functions. Enrollment and disenrollment information held by the Sponsoring Employer is held in its capacity as an employer and is not PHI.

(ii) Summary Health Information - On behalf of the Plan, the Plan Administrator may disclose Summary Health Information to the Sponsoring Employer, provided that the Sponsoring Employer requests the Summary Health Information for the purpose of (i) obtaining premium

bids from health plans for providing health insurance coverage under the Plan; or (ii) modifying, amending, or terminating the Plan. Summary Health Information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a Sponsoring Employer has provided benefits under the Plan; and from which the information described at 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code; or

(iii) PHI Released through a valid Authorization - PHI disclosed to the Plan or the Sponsoring Employer under a signed authorization that meets the requirements of the HIPAA privacy rules.

Notwithstanding the above election, however, the Plan Administrator may encounter a situation in which it determines that its ERISA fiduciary duties necessitate that it access PHI in order to carry out Plan administration functions described above. In that event, the Plan Administrator shall adopt new policies and procedures to comply with the change from “hands-off” status to “involved” status (as that term is commonly used in the context of HIPAA compliance to signify that the Sponsoring Employer and its employees generally will have access to PHI from the Plan Administrator for Plan administration purposes), and the Plan Administrator shall take such further steps necessary to ensure that the Plan complies with HIPAA’s additional requirements for involved plan sponsors.

ARTICLE IX

Federal Laws Affecting Benefits

9.1 Rights for Mothers and Newborn Children

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

9.2 Women’s Health and Cancer Rights Act

The Plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breast, prostheses, and complications resulting from a mastectomy, including lymphedema. Reconstructive benefits are subject to annual Plan deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the Plan. Contact the Plan Administrator for more information.

9.3 Michelle’s Law

Effective January 1, 2010, the provisions of Michelle's Law apply, notwithstanding anything contained herein to the contrary.

9.4 Mental Health Parity

Effective January 1, 2010, no Welfare Benefit program that provides both medical and surgical benefits and mental health and/or substance abuse benefits shall violate the provisions of Section 712 of ERISA in accordance with the Mental Health Parity and Addiction Equity Act.

9.5 GINA

Effective January 1, 2010, the provisions of the Genetic Information Nondiscrimination Act apply, notwithstanding anything contained herein to the contrary.

9.6 FMLA

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3. The FMLA allows eligible Employees to take up to 12 weeks of leave each year for serious illness, the birth or adoption of a child, or to care for a spouse, child, or parent who has a serious health condition.

If your request for a leave is approved, group health coverage for you and any covered dependents continues as long as you continue to pay your portion of the cost for your benefits during the leave. If you take a paid leave of absence, the cost of group health coverage will continue to be deducted from your pay on a before-tax basis. If you take an unpaid leave of absence that qualifies under FMLA, your participation continues as long as you contribute your share of the cost of group health coverage during the leave on an after-tax basis. For additional information on FMLA leaves, please contact your human resources representative.

If you lose any group health coverage during an FMLA leave because you did not make the required contributions, you may reenroll when you return from your leave and you will be reinstated on the same terms that applied prior to taking such FMLA leave. Your group health coverage will start again on the first day after you return to work and make your required contributions.

When you take an FMLA leave, the entire amount you elected under your Health FSA will be available to you during your leave period, less any prior reimbursement, as long as you continue to make your contributions during your leave of absence. If you stop making contributions, your coverage under the Health FSA will terminate while you are on FMLA leave. In that case, you may not receive reimbursement for any health care expenses you incurred after your coverage terminated.

If your coverage terminates during your leave, you may be reinstated in your Health FSA election, if you return to work during the same year in which your leave began. You will have the choice of either resuming your contributions at the same level in effect before your FMLA

leave, or you may elect to increase your contribution level to “make up” for the contributions you missed during your leave. If you simply resume your prior contribution level, then the amount available for reimbursement for the year will be reduced by the contributions you missed during the leave. If you elect make-up contributions, then the amount available for reimbursement will be the same amount you could receive immediately before the leave.

Regardless of whether you choose to resume your former contribution level, or make up for missed contributions, you may not retroactively elect Health FSA coverage for expenses incurred after your coverage terminated.

9.7 HIPAA

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

You and your eligible dependents that lose group health coverage must receive certification of your coverage under the Plan. You may need this certification in the event you later become covered by a new plan under a different employer or under an individual policy.

You and your eligible dependent(s) will receive a coverage certification (i) when your Plan coverage terminates, (ii) when COBRA coverage terminates (if you elected COBRA), and (iii) upon your request (if the request is made within 24 months following either termination of coverage).

You should keep a copy of the coverage certification(s) you receive, as you may need to prove you had prior coverage when you join a new health plan. For example, if you obtain new employment and your new employer’s plan has a pre-existing condition limitation (which delays coverage for conditions treated before you were eligible for the new plan), the employer may be required to reduce the duration of the limitation by one day for each day you had prior coverage (subject to certain requirements). If you are purchasing individual coverage, you may need to present the coverage certification to your insurer at that time as well.

9.8 USERRA

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment and Reemployment Rights Act (USERRA) and the regulations thereunder.

If you take a military leave, whether for active duty or for training, you are entitled to extend your medical coverage for up to 24 months as long as you give the Employer advance notice of the leave (with certain exceptions). Your total leave, when added to any prior periods of military leave from the Employer, cannot exceed five years (with certain exceptions).

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the amount you paid before the leave. If the entire length of the leave is 31 days or

longer, you may be required to pay up to 102% of the full amount necessary to cover an Employee who is not on military leave.

If you take a military leave, but your coverage under the Plan is terminated, for instance, because you do not elect the extended coverage, you will be treated as if you had not taken a military leave upon reemployment when determining whether an exclusion or waiting period applies.

9.9 Designation of Primary Care Providers and/or OB/GYN

Programs may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. In some cases, until you make this designation, a Plan may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Cross Blue Shield of Massachusetts.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Blue Cross Blue Shield of Massachusetts.

ARTICLE X

Miscellaneous

10.1 No Guarantee of Employment

No provision of the Plan shall restrict the Employer from discharging a Participant from employment or restrict any Participant from resigning from employment with the Employer.

10.2 Plan Provisions Binding

The provisions of the Plan shall be binding upon the Employer, all Eligible Employees, all Dependents, all Non-Tax Dependents, and all beneficiaries and their respective successors, heirs and legal representatives.

10.3 Rules of Interpretation

Words of gender shall include persons and entities of any gender, the plural shall include the singular, and the singular shall include the plural. Captions are intended to assist in reference and shall not be interpreted as part of the Plan. In the event of any conflict between the provisions of this Plan document and the provisions of any of the applicable documents

governing any participating Welfare Benefit program, the provisions of this Plan document shall supersede such other provisions.

10.4 Governing Law and Jurisdiction

Subject to the applicable provisions of ERISA which provide to the contrary, this Plan shall be administered, construed and enforced according to the laws of the Commonwealth of Massachusetts or such other State as may be provided for in an insurance contract with respect to matters governed thereby.

A claimant that seeks to commence a lawsuit or legal action against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Plan Sponsor, or any other person or committee, in connection with the Plan must do so in the United States District Court with jurisdiction over the area in which the Employer's corporate headquarters is located, Such United States District Court is the sole forum for a claimant bringing a lawsuit.

10.5 Severability

The invalidity of any particular clause or provision of the Plan shall not invalidate all or any part of the remainder of the Plan, but such remainder shall be and remain valid in all respects as fully as the law will permit.

10.6 Nonassignability of Rights

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law. A direct payment by the Plan to a person or entity that provides medical services to a Plan participant is not a waiver of this provision. Additionally, a medical service provider may not bring a claim for benefits against the Plan, a Plan fiduciary, the Plan Administrator, or the Employer with respect to the services it provides to a Plan participant.

10.7 Payment of Expenses

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

10.8 Employer's Protective Clauses

10.8.1 Insurance purchase

Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's benefits shall be limited to the insurance premium(s), if any, that remained unpaid

for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.

10.8.2 Validity of insurance contract

The Employer shall not be responsible for the validity of any insurance contract issued hereunder or for the failure on the part of the insurer to make payments provided for under any insurance contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Employer.

10.9 No Guarantee of Tax Consequences

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

10.10 Indemnification of Employer by Participants

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

10.11 Funding

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific benefit, but may instead be considered general assets of the Sponsoring Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

10.12 Severability

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

10.13 Captions

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

ARTICLE XI

Statement of ERISA Rights

11.1 Statement of ERISA Rights

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants shall be entitled to the following:

11.1.1 Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

11.1.2 Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions

under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

11.1.3 Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including the Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

11.1.4 Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

No action at law or in equity may be brought to recover under the Plan until the appeal rights herein provided have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part.

11.1.5 Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If

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

General Information

Plan Name	The Ocean Spray Cranberries, Inc. Welfare Benefit Plan
Plan Number	501
Plan Sponsor	Ocean Spray Cranberries, Inc. One Ocean Spray Drive Lakeville-Middleboro, MA 02349
Employer Identification Number	04-1215610
Plan Administrator	Pension and Savings Committee of Ocean Spray Cranberries, Inc. One Ocean Spray Drive Lakeville-Middleboro, MA 02349 508-946-1000
Agent for Service of Legal Process	Plan Administrator
Plan Year	January 1 through December 31
Plan Type	Welfare benefit plan providing the following types of benefits: • Health Benefit (Medical) (self-funded) • Health Benefit (Prescription) (self-funded) • Dental (administered by insurance contract) • Vision (administered by insurance contract) • Health Care Flexible Spending Accounts (self-funded) • Short-term disability (both self-funded and administered by insurance contract) • Long-term disability (administered by insurance contract) • Basic life insurance (administered by insurance contract) • Optional life insurance (administered by insurance contract) • Dependent life insurance (administered by insurance contract) • Accidental death and dismemberment insurance (administered by insurance contract) • Supplemental accident death and dismemberment insurance (administered by insurance contract) • Hospital Care (administered by insurance contract) • Critical Illness (administered by insurance contract) • Long-term care insurance (administered by insurance contract) • Business travel accident insurance (administered by insurance contract)
Source of Contributions	Both Ocean Spray and Plan Participants share in the cost of contributions to certain of the benefits offered within the Plan. Ocean Spray determines the amount of participant contributions each year.

Insurers and Third-Party Administrators

Self-Insured Benefits (Benefits administered by a third-party administrator)

▪ Health Benefit (Medical)	Blue Cross and Blue Shield of Massachusetts P.O. Box 9131 N. Quincy, MA 02171-9131 (800) 872-5298
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▪ Health Benefit (Prescription Drug)	Express Scripts PO Box 52150 Phoenix, AZ 85072-9954(800) 282-2881
▪ Health Care Flexible Spending Account	Sentinel Financial Group 55 Walkers Brook Drive, Suite 100 P.O. Box 5000 Reading, MA 01867 (888) 762-6088
<i>Fully Insured Benefits (Benefits administered through an insurance contract)</i>	
▪ Dental	Delta Dental of Massachusetts 465 Medford Street Boston MA 02129 (800) 872-0500
▪ Vision	VSP P.O. Box 997105 Sacramento, CA 95899-7105 (800) 877-7195
▪ Short-Term Disability ▪ Long-Term Disability	The Hartford One Hartford Plaza Hartford, CT 06155 (800) 303-9744
▪ Basic Life Insurance ▪ Optional Life Insurance ▪ Dependent Life Insurance ▪ Accidental Death/Dismemberment Insurance ▪ Supplemental Accidental Death and Dismemberment Insurance ▪ Hospital Care ▪ Critical Illness	The Hartford One Hartford Plaza Hartford, CT 06155 (800) 303-9744
▪ Long-Term Care Insurance	Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122(877) 286-2852
▪ Business Travel Accident Insurance	Chartis 100 Connell Drive Berkeley Heights, NJ 07926

Appendix A – Evidence of Coverage Documents

This SPD should be read in combination with the insurance contracts, evidence of coverage documents (together and individually referred to as “EOCs”) provided by the insurance companies and service providers. The EOCs describe the benefits available under the Plan, and when read with this SPD, are intended to meet ERISA’s SPD requirements.

Please see the EOCs for details of Plan benefits. For additional information or for copies of the EOCs, please contact the Plan Administrator. Union locations should contact their local H.R. Manager.

List of EOCs

Health Benefit (Medical) – Blue Cross and Blue Shield of Massachusetts

Health Benefit (Prescription Drug) – Express Scripts

Dental – Delta Dental of Massachusetts

Vision – VSP

Short-term disability – The Hartford

Long-term disability – The Hartford

Basic life, optional life, dependent life, AD&D, and supplemental AD&D, Hospital Care,

Critical Illness – The Hartford

Long-term care insurance – Unum Life Insurance Company of America

Business travel accident – Chartis

OCEAN SPRAY CRANBERRIES, INC.

EMPLOYEE BENEFITS PLAN

APPENDIX B

Look-Back Measurement Method

This Appendix, effective January 1, 2019, describes the health insurance eligibility provisions applicable to employees who are not eligible to Participate in the health insurance benefit solely because they are not regularly scheduled to work at least 30 hours per week. In the event there is a conflict between Appendix B and another Plan provision, the Plan terms will control; provided that it is the intention of the Employer that this Appendix B be given effect to the fullest extent possible.

A. DEFINITIONS

Terms defined in the Plan shall have the same meanings when used in this Appendix, except as provided below. In addition, the following words and phrases shall have the meanings stated:

1. **“Break in Service”** means a period of:

- Thirteen (13) consecutive weeks (or more) during which an Employee has no, and is not credited with any, Hours of Service, or
- At the Plan Administrator’s discretion, four (4) consecutive weeks (or more) during which an Employee has no, and is not credited with any, Hours of Service, if the period with no Hours of Service is greater than the immediately preceding period of employment.

2. “Code” means Internal Revenue Code of 1986, as amended, and regulations issued thereunder or pursuant thereto.
3. “Employee” means a common-law employee currently performing services under the Employer’s control, except for employees excluded under section B.1. Employee Eligibility Requirements.
4. “Employer” means the Plan Sponsor.
5. “Hours of Service” means an hour for which an Employee is (A) paid, or entitled to payment, for the performance of duties for the Employer, or (B) entitled to payment by the Employer due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. Notwithstanding the foregoing, hours paid through disability benefits from coverage purchased by employees on an after-tax basis or hours paid solely to comply with a workers’ compensation law will not be treated as hours of service.
6. “Initial Administrative Period” means the one (1) month period beginning immediately after the end of the Initial Measurement Period and ending immediately before the start of the Initial Stability Period. The Initial Administrative Period also includes the period between a new Employee’s hire date and the beginning of the Initial Measurement Period, to the extent that the Initial Measurement Period does not begin on the new Employee’s date of hire.
7. “Initial Measurement Period” means the period beginning on the first day of the calendar month following the Employee’s start date and ending twelve (12) months later. The Employer shall measure the Employee’s Hours of Service during the Initial Measurement Period as described in Paragraph B of this Appendix.
8. “Initial Stability Period” means the period of time beginning immediately after the Initial Administrative Period and ending twelve (12) months later or on the first day of the first standard stability period applicable to the Employee, if later.
9. “Ongoing Employee” means an Employee who has been employed by the Employer for at least one complete Standard Measurement Period.
10. “Part-time Employee” means a new Employee who is not regularly scheduled to work 22.5 hours per week or more, and whom the Employer reasonably expects at the time of hire to work on average less than 30 Hours of Service per week during the Initial Measurement Period.
11. “Seasonal Employee” means an Employee who is hired into a position for which the Employer determines that the customary annual employment is six months or less and at approximately the same time each year.
12. “Standard Administrative Period” means the two (2) month period beginning immediately after the end of the Standard Measurement Period and ending immediately before the start of the Standard Stability Period.

13. “Standard Measurement Period” means the twelve (12) month period beginning November 1 and ending each October 31. The Employer shall measure an Ongoing Employee’s Hours of Service during the Standard Measurement Period as described in as described in Paragraph B of this Appendix.
14. “Standard Stability Period” means the Plan Year (i.e., January 1 through December 31) immediately following the end of a Standard Measurement Period and Standard Administrative Period.
15. “Variable Hour Employee” means a new Employee who is not regularly scheduled to work 30 hours or more per week, and with respect to whom, based on the facts and circumstances at the Employee’s start date, the Employer cannot reasonably determine whether the Employee will average at least 30 Hours of Service per week over the Initial Measurement Period because the Employee’s hours are variable or otherwise uncertain.

B. ELIGIBILITY

1. An Employee not otherwise eligible for the health insurance benefit solely because he or she is not regularly scheduled to work at least 30 hours per week shall be eligible for Plan participation on:
 - For an Ongoing Employee, the first day of the Plan Year following the end of the Standard Measurement Period in which the Employee averaged at least 30 Hours of Service per week.
 - For Part-time, Variable Hour and Seasonal Employees, if the Employee averages at least 30 Hours of Service per week during the Initial Measurement Period, such Employee will be eligible as of the first day of the Initial Stability Period, which shall be no later than the first of the month following 13 consecutive months after the Employee’s date of hire. However, if the Employee experiences a change in employment status during the Initial Measurement Period such that, had the Employee begun employment in the new position or status, the Employee would have been expected to work at least 30 Hours of Service per week (and would not have been a Seasonal Employee), the Employee will be eligible for Plan benefits as soon as administratively practicable, but no later than the first day of the fourth full calendar month following the change, or, if earlier, the first day of the Initial Stability Period after an Initial Measurement Period during which the Employee averages at least 30 Hours of Service.
2. The Employer intends to use the look-back measurement method in Treas. Reg. §54.4980H-3(d) to determine which Ongoing, Part-Time, Variable Hour, and Seasonal Employees are eligible for benefits under the health insurance benefit. However, the Employer retains its discretion to determine who is eligible for benefits. A person that the Employer classifies as not a full-time employee shall not be eligible to participate in the Plan’s benefits, regardless of whether such person is determined by a court, the IRS or other regulatory authority to be full-time under Treas. Reg. §54.4980H.
3. To the extent that the eligibility rules in this Appendix B do not address a specific eligibility issue, the Employer shall have discretion to make eligibility determinations consistent with applicable law and regulations, including special rules for changes in employment status and special unpaid leaves of absence which occur during a measurement or stability period.

4. Part-Time, Variable Hour, or Seasonal Employees who have not averaged at least 30 Hours of Service per week during the Initial Measurement Period are not eligible to participate in the health insurance benefit under the look-back measurement method. Notwithstanding the foregoing, if an Employee returns to work after an unpaid leave of absence without a Break in Service, the Employee will be eligible for benefits upon return if the Employee returns during an Initial Stability Period or Standard Stability Period in which the Employee is eligible for Plan benefits under Paragraph B of this Appendix B. If the Employee returns to work after a Break in Service, the Employee will be treated as an Employee who has not worked an entire Standard Measurement Period to the extent permissible by law, except that the Employee will not be treated as an Employee who has not worked an entire Standard Measurement Period if the Employee is returning to work after a leave that is for jury duty, FMLA leave, USERRA leave, state mandated or job projected leave, or any approved leave of absence.

To the extent that the Plan and/or a Plan feature's provider contracts and/or other plan documents refer to the eligibility of "employees," only individuals classified as "employees" by the Plan Sponsor are eligible to participate in such Plan feature. Independent contractors, freelancers and individuals hired through staffing firms shall not be eligible even if they are subsequently determined to be common law employees for any purpose, including without limitation, for wage, labor or tax purposes by the Internal Revenue Service, the Department of Labor or any other Federal or state agency, administrative body or court. Any such determination should have a prospective effect only.

5. If an Employee in an Initial Stability Period or Standard Stability Period fails to pay the Employee's share of the cost of coverage on a timely basis, coverage under the health insurance benefit shall terminate on the date that payment is due, provided that the employee will have a grace period of 30 days from the date the payment is due to remit payment

APPENDIX C
THE HEALTH SAVINGS ACCOUNT PROGRAM
ARTICLE I

PLAN ESTABLISHMENT

1.1 Purpose

The purpose of this Appendix C is to set forth the provisions governing the Health Savings Account (HSA) Program. The HSA Program is created exclusively to permit an HSA-Eligible Employee to make contributions to an Eligible HSA.

1.2 Qualification

The HSA Program is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of “qualified eligible medical expenses” as set forth in Code Section 223(d)(2). The HSA Program is an elective pre-tax option under the Plan, and is intended to constitute accident and health plan coverage under Code Section 106.

1.3 Incorporation By Reference

The terms of the Plan are incorporated by reference wherever they apply to the HSA Program’s operation.

1.4 Duration

The HSA Program is established with the intent of being maintained for an indefinite period of time; however, the Plan Sponsor, in its sole and absolute discretion, and in accordance with the provisions of Article VI of the Plan, may amend or terminate the HSA Program or any of the provisions herein.

1.5 Use of Terms

Terms used in this Appendix C shall have the same meanings as the terms defined in Article II of the Plan, unless separately defined in this Appendix C. All of the terms and provisions in Articles I through XI of the Plan shall apply to this Appendix C, except that where the provisions of this Appendix C and Articles I through XI of the Plan conflict, the provisions of this Appendix C shall govern.

ARTICLE II

DEFINITIONS

2.1 Eligible HSA

An Eligible HSA, as used in this Appendix C, means an HSA that is established and maintained by an HSA-Eligible Employee through the HSA trustee or custodian selected by the Plan Sponsor and offered in conjunction with the Employee's enrollment in a High Deductible Health Plan sponsored by the Plan Sponsor.

ARTICLE III

PARTICIPATION AND TERMS

3.1 Participation, Contributions and Elections

HSA-Eligible Employees may elect to contribute to the HSA Program on a prospective basis by enrolling under the terms of Section 3.2 of the Plan. As described in Section 3.1.2 of the Plan, such election can be increased or decreased prospectively at any time during the Plan Year, effective no later than the next available payroll date following the Plan Sponsor's receipt of a completed election change form. Subject to the terms and conditions of Articles I through XI of the Plan and this Appendix C, as part of an Employee's participation under the terms of Section 3.1.2 of the Plan, any HSA-Eligible Employee may elect to contribute an amount to an Eligible HSA.

3.2 Annual Contribution Limits

The maximum amount that an HSA-Eligible Employee may elect to contribute to an Eligible HSA during the Plan Year is the statutory maximum amount for HSA contributions applicable to the Participant's High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made, determined pursuant to Code Section 223(b)(2).

If the HSA-Eligible Employee attains (or will attain) age 55 by the end of any calendar year, the annual contribution limit is increased by the catch-up limit applicable for that calendar year (as determined pursuant to Code Section 223(b)(3)).

The annual contribution limit shall be reduced by any HSA contributions made by the Plan Sponsor on behalf of the HSA-Eligible Employee. For Employees who elect to participate in the Plan Sponsor's High Deductible Health Plan, the Plan Sponsor will make a one-time contribution per lifetime to the Employee's HSA, in the amount of \$500 (for individual coverage or \$1000 (for two-person or family coverage) or such other amount as provided in the initial and annual open enrollment materials furnished to Employees. The Plan Sponsor HSA contribution shall be provided at the time of the Employee's first Open Enrollment HSA election. The annual contribution limit (and the catch-up limit, if applicable) will be prorated by the number of months during the Plan Year in which the Employee is an HSA-Eligible Employee unless the HSA-Eligible Employee is enrolled in a High Deductible Health Plan prior to December 1 of a given

year and remains enrolled in the High Deductible Health Plan through the end of the calendar year, in which case the Employee may elect the entire annual contribution limit (including the catch-up contribution, if otherwise eligible). However, in order for such Employee's contribution to retain its tax-favored status, the Employee must remain covered by any high deductible health plan qualified under Code Section 223(c)(2) for 12 months after the end of the year in which he or she enrolled in a High Deductible Health Plan sponsored by the Plan Sponsor.

ARTICLE IV

MISCELLANEOUS

4.1 Administration of the HSA Program

The Plan Sponsor shall transfer any pre-tax HSA contribution amounts elected by an HSA-Eligible Employee directly to the HSA trustee or custodian. The Plan Administrator shall maintain records of such HSA contribution amounts, and shall provide this information to the Plan Sponsor so that the Plan Sponsor may appropriately report this information on the Employee's Form W-2. The Plan Sponsor shall have no responsibility, authority or control over such HSA contribution amounts once such amounts are transferred to the HSA trustee or custodian.

4.2 HSA Program and ERISA

The HSA benefits under this Plan consist solely of the ability to make contributions to the HSA on a pre-tax salary reduction basis and any Plan Sponsor contributions to such HSA as set forth in Section 3.2.3. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claim procedures, etc.) shall be provided and are set forth in the HSA, not this Plan. The HSA Program is not an employer-sponsored employee welfare benefit plan within the meaning of Section 3(1) of ERISA. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code Section 223(d)(2). The Plan Sponsor's only involvement with the HSA Program is to forward to the HSA provider(s) contributions that Employees make via pre-tax salary reductions and that the Plan Sponsor contributes on behalf of Employees, and to select an HSA trustee or custodian to facilitate the establishment of an HSA by HSA-Eligible Employees who enroll in a High Deductible Health Plan sponsored by the Plan Sponsor. The Plan Sponsor shall maintain records to keep track of HSA contributions Employees make via pre-tax salary reductions and that the Plan Sponsor contributes on behalf of Employees, but it shall not create a separate fund or otherwise segregate assets for this purpose. The Plan Sponsor has no authority or control over the funds deposited into an HSA.

4.3 Amount Payable

The tax treatment of the HSA (including contributions and distributions) is governed by Code Section 223.

Executed this 30 day of October, 2019.

OCEAN SPRAY CRANBERRIES, INC.

By: Jane Borkowski

Name: Jane Borkowski

Title: VP, Global Corp Affairs + CFO