

**CHE TRINITY
WELFARE BENEFIT PLAN
Effective as of January 1, 2014**

[Formerly known as the Trinity Health Corporation Welfare Benefit Plan]

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ARTICLE I

INTRODUCTION

Section 1.1 Background. Trinity Health Corporation (“Trinity Health”) previously adopted the Trinity Health Corporation Welfare Benefit Plan (“Plan”) to provide health and welfare benefits and programs for eligible Employees of Trinity Health and affiliates of Trinity Health that adopt the Plan and their Dependents and other beneficiaries. During 2013, Trinity Health consolidated with Catholic Health East under a common parent, CHE Trinity Inc., a/k/a/ “CHE Trinity Health.” Effective as of January 1, 2014, the effective date of this restatement of the Plan, it continues to be sponsored by Trinity Health for employees of Trinity Health and its subsidiary affiliates, and does not cover employees of Catholic Health East and its subsidiary affiliates. The name of the Plan shall, however, be changed to CHE Trinity Welfare Benefit Plan. The Plan constitutes two separate ERISA welfare benefit plans – Plan 504 and Plan 505. Plan 504 contains the benefit programs listed on Appendix A and is comprised of all of the medical benefits as well as certain other health benefits provided by Trinity Health and other participating affiliated employers. Plan 505 contains the benefit programs listed on Appendix B and is comprised of those health and welfare benefits other than the medical benefits listed on Appendix A.

Section 1.2 Plan Restatement. Effective as of January 1, 2014, Trinity Health amends and restates the Plan as provided herein. The provisions of this Plan will apply to both Plan 504 and Plan 505, except where provided otherwise herein. Capitalized terms that are not otherwise defined shall have the meanings set forth in Article II.

Section 1.3 Incorporation of Provisions. The Benefits and Optional Benefit Programs provided under the Plan, and the general terms and conditions governing the same, are set forth in (a) this document, (b) one or more Summary Plan Descriptions (collectively, the “SPDs”), copies of which are provided to Participants, and (c) other Incorporated Documents, if any. The SPDs and other Incorporated Documents (hereinafter, collectively, “Incorporated Documents”), as the same may be amended from time to time, are hereby incorporated herein by reference and made a part of this Plan.

Section 1.4 Purpose of Plan. The purpose of the Plan is to provide eligible Employees and their Dependents and other beneficiaries with certain health and welfare benefits and, in certain circumstances, to provide eligible Employees with a choice between cash and certain “qualified benefits,” as defined in Code Section 125(f).

Section 1.5 Type of Plan. The Plan includes a cafeteria plan under Code Section 125 (the “Cafeteria Plan”), and such portion of the Plan is to be interpreted in a manner consistent with the requirements of Code Section 125 and the Regulations issued thereunder. Further, although contained within this document, the Cafeteria Plan shall be considered a separate written plan and separate program for purposes of administration and nondiscrimination requirements imposed under Code Section 125. The Cafeteria Plan component provides eligible Employees with a choice between cash and certain qualified fringe benefits under the Premium Conversion Program, the Health Care Flexible Spending Account Program, and the Dependent Care Flexible Spending Account Program, and, effective January 1, 2014, the Health Savings Account Program. Certain other Benefits may be offered or available outside of the Cafeteria Plan contained in the Plan, including the Health Reimbursement Account Program and Benefits for Dependents who are not Tax Dependents. The Dependent Care Flexible Spending Account Program is intended to qualify as a “dependent care assistance plan” under

Code Section 129, and the Eligible Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code Section 129(a). The Health Care Flexible Spending Account Program and Health Reimbursement Account Program are intended to qualify as "self-insured medical reimbursement plans" under Code Section 105, and the Eligible Medical Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code Section 105(b). Although reprinted within this document, the Dependent Care Flexible Spending Account Program, Health Care Flexible Spending Account Program and Health Reimbursement Account Program shall be considered separate written plans and separate programs for purposes of administration and nondiscrimination requirements imposed by Code Sections 129 and 105, respectively.

Section 1.6 ERISA Plan Status. The Plan, together with each Benefit and each Optional Benefit Program, other than the Cafeteria Plan portion of the Plan, the Dependent Care Flexible Spending Account Program, and the Health Savings Account Program, is intended to constitute an "employee welfare benefit plan," as defined in ERISA. Trinity Health has made an election under Code Section 410(d) for Plans 504 and 505 to be subject to the applicable provisions of ERISA. For purposes of ERISA, each Incorporated Document, including those listed on an Appendix attached hereto, shall be incorporated herein, and the terms of this Plan shall include the terms of any such document. To the extent that a conflict arises between an Incorporated Document and the Plan, the provisions of the Incorporated Document will control unless otherwise stated herein.

ARTICLE II

GENERAL DEFINITIONS

The following terms, when used in this Plan, have the meaning set forth in this Article II unless another meaning is clearly indicated from the context.

Section 2.1 Administrator. The Plan Sponsor or such officer or employee of the Plan Sponsor appointed as Administrator by the Committee. The Plan Sponsor serves as the "Plan Administrator" of the Plan, as defined in Section 3(16) of ERISA, unless another party is appointed as Administrator.

Section 2.2 Affiliated Employer. Any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes an Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with an Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes an Employer; and any other entity required to be aggregated with an Employer pursuant to Regulations under Code Section 414(o).

Section 2.3 Agreement. The procedures established by the Administrator by which an eligible Employee enrolls in the Plan and agrees to the terms of coverage under one or more of the Optional Benefit Programs or other Benefits.

Section 2.4 Benefit or Benefits. Any of the health and welfare benefits or coverage provided by the Employer to Participants under the Plan and their Dependents (if applicable), including, but not limited to, benefits provided under all benefit programs, insurance contracts, agreements and Incorporated Documents (some of which are listed in an Appendix hereto), and benefits made available to Participants under the Optional Benefit Programs. The specific types and amounts of Benefits available, the requirements for participation and other terms and conditions of coverage and receipt of each Benefit are set forth in the Incorporated Documents. Not all Benefits are available to all Employees or apply to all locations.

Section 2.5 Board of Directors. The Plan Sponsor's board of directors or any other individual or committee delegated the authority of the Plan Sponsor's board of directors to carry out any or all of the functions assigned to that body under the Plan.

Section 2.6 Claimant. A Participant or covered Dependent or his or her heir, legatee, administrator, executor, personal representative, beneficiary, or assign, who may make a claim for a Benefit under the Plan.

Section 2.7 Code. The Internal Revenue Code of 1986, as amended from time to time.

Section 2.8 Committee. The CHE Trinity Benefits Committee, as from time to time constituted, which assists the Plan Sponsor in the administration of the Plan.

Section 2.9 Compensation. The total wages and salary paid during the Plan Year or Period of Coverage by the Employer to an Employee for personal services rendered during the Plan Year or Period of Coverage, or as otherwise defined in the applicable Incorporated Document or, if silent, under the applicable section of the Code. Notwithstanding the foregoing,

if not otherwise defined to the contrary in an Incorporated Document, Compensation shall also include all Contributions made to the Plan by the Participant. With respect to a former Employee, Compensation includes severance pay received from an Employer in accordance with the terms of the Severance Plan or another severance agreement or policy.

Section 2.10 Contributions and Employer Contributions. For each Plan Year or Period of Coverage, the amount (if any) of Compensation allocated toward the purchase of Benefits or participation in the Optional Benefit Programs under the Plan, which shall be equal to the sum of the following:

- A. The amount (if any) by which a Participant agrees (or is deemed to agree) to reduce his or her Compensation for the Plan Year or Period of Coverage (or remaining portion thereof), pursuant to his or her Agreement or based on the Benefits and Optional Benefit Programs elected by the Participant for the Plan Year or Period of Coverage (or remaining portion thereof). If a Participant does not elect to have Compensation allocated towards the purchase of Benefits or participation in the Optional Benefit Programs under the Plan pursuant to an Agreement, the Participant is deemed to have elected to have his or her Compensation allocated towards the purchase of the Benefits and Optional Benefit Programs elected by the Participant for a Plan Year or Period of Coverage on a pre-tax basis with respect to the Optional Benefit Programs and Benefits that may be paid for on a pre-tax basis and on an after-tax basis with respect to the Benefits that must be paid for on an after-tax basis; provided, however, that the Participant is deemed to have elected to have his Compensation allocated towards the purchase of the Benefits for the Participant's Dependents who are not the Participant's Tax Dependents on an after-tax basis. A Participant's Compensation for a Plan Year or Period of Coverage (or portion thereof) shall be reduced only by way of payroll withholding, and such reduction shall generally be made on a ratable basis throughout the applicable Plan Year or Period of Coverage (or portion thereof), or in accordance with the applicable costs allocable to the period in question. The extent to which, if at all, the Compensation deductions described in this paragraph will be available for a Plan Year or Period of Coverage shall be determined by the Employer, in its sole discretion, prior to the first day of each Plan Year or Period of Coverage.
- B. The amount (if any) of Contributions to the Plan made by the Employer on behalf of Participants that are not allocated solely to the cost of a particular Benefit or Optional Benefit Program or that are contributed or deemed to be contributed to the Health Reimbursement Accounts or Health Savings Accounts of Participants ("Employer Contributions"). The extent to which, if at all, this paragraph will be available for a Plan Year or Period of Coverage shall be determined by the Employer in its discretion, prior to the first day of each Plan Year or Period of Coverage. If Employer Contributions are made to the Plan, and, to the extent permitted, a Participant elects to receive his or her share of those Contributions in cash (the "cash-out option") rather than to allocate those Contributions to cover the cost of one or more Benefits or Optional Benefit Programs, the cash shall be distributed directly from the Employer to the Participant ratably over the Plan Year or Period of Coverage for which it was available to be contributed to the Plan. Such additional cash Compensation shall be in the amount defined by the Employer or in applicable Incorporated Documents. The Employer reserves the

right to require the Employee to provide satisfactory evidence of similar coverage elsewhere as a condition of electing the cash-out option.

Section 2.11 Dependent. Except as otherwise provided in Article V of this Plan or in an Incorporated Document, a Dependent is an individual who is:

- A. The legal Spouse of a Participant.
- B. The Non-Spouse Eligible Adult of a Participant.
- C. A Participant's Eligible Child through the end of the Plan Year in which the child attains age 26, regardless of the child's residency, employment, financial dependence, student status, marital status or status as a tax dependent as defined in the Code; provided, however, that the spouse of an Eligible Child does not qualify as a Dependent under the Plan.
- D. A Participant's unmarried Eligible Child after the end of the Plan Year in which the child attains age 26 if the Eligible Child satisfies all of the following requirements:
 - 1. The child is incapable of self-sustaining employment because of mental or physical incapacitation ("Disabled");
 - 2. The child became Disabled prior to the end of the Plan Year in which he or she attained age 26;
 - 3. The child has been continuously enrolled in the Plan prior to his or her 26th birthday;
 - 4. The child is the Participant's Tax Dependent; and
 - 5. The child has not reached an age, if any, that would otherwise make him or her ineligible for coverage under an Incorporated Document.
- E. Except as otherwise provided in an Incorporated Document:
 - 1. An eligible Employee and his or her Spouse, Non-Spouse Eligible Adult or Eligible Child may not be covered under the Plan as both a Dependent and a Participant;
 - 2. Coverage shall not be duplicated for an eligible Dependent of both an eligible Employee and his or her Spouse or Non-Spouse Eligible Adult; and
 - 3. The following children of an Employee's Non-Spouse Eligible Adult who is not the Employee's Tax Dependent are not eligible for coverage under any Benefit program or Optional Benefit Program under the Plan unless the Non-Spouse Eligible Adult is enrolled in such Benefit program or Optional Benefit Program and such child will cease to be a Dependent when the Non-Spouse Eligible Adult ceases to be a Dependent or, with respect to any Benefit program or Optional Benefit Program, when the

Non-Spouse Eligible Adult ceases to be covered under the Benefit program or Optional Benefit Program:

- a. A biological child or legally adopted child of the Non-Spouse Eligible Adult who is not also the eligible Employee's biological child or legally adopted child, respectively;
 - b. A child placed for adoption with an eligible Employee's Non-Spouse Eligible Adult who is not also placed for adoption with the eligible Employee; and
 - c. A child for whom the eligible Employee's Non-Spouse Eligible Adult, but not the eligible Employee, is the court-appointed legal guardian.
- F. With respect to the Medical Benefit Program (including Prescription Drug Program), an Eligible Child who is a full-time student will not cease to be a Dependent solely due to the fact that the Eligible Child takes a medically necessary leave of absence (or reduces hours to part-time status for a medically necessary reason) from an accredited college or university. The medically necessary leave of absence (or reduction of hours) must be verified by written certification from the Eligible Child's treating physician. The Eligible Child must be enrolled in the Medical Benefit Program as a Dependent immediately prior to the medically necessary leave of absence (or reduction of hours) and the absence must otherwise cause the Eligible Child to lose coverage under the Medical Benefit Program. The Eligible Child will continue to be a Dependent for one year after the first day of any verified medically necessary leave of absence or, if earlier, the date coverage would otherwise terminate under the Medical Benefit Program.

Section 2.12 Dependent Care Flexible Spending Account Program. The Optional Benefit Program established under Article V for the reimbursement of Eligible Dependent Care Expenses. The Employer may, in its discretion, determine the periods of time during which it will and will not offer the Dependent Care Flexible Spending Account Program to otherwise eligible Employees.

Section 2.13 Effective Date. The effective date of this amended and restated Plan is January 1, 2014, unless a different effective date is provided herein.

Section 2.14 Election Period. The time period established by the Administrator during which an Employee or Participant may make or change his or her Agreement regarding Benefits and Optional Benefit Programs. For new Employees, the Election Period shall generally occur at the time of employment. For existing Employees and Participants, the Election Period shall generally occur prior to the beginning of each Plan Year, Period of Coverage, or at any other such time that an Employee becomes eligible to participate in the Plan.

Section 2.15 Eligible Child. An Eligible Child is:

- A. A biological child of an eligible Employee, eligible Employee's legal Spouse or eligible Employee's Non-Spouse Eligible Adult;

- B. A legally adopted child of or child placed for adoption with an eligible Employee, eligible Employee's legal Spouse or eligible Employee's Non-Spouse Eligible Adult; or
- C. A child for whom the eligible Employee, eligible Employee's legal Spouse or eligible Employee's Non-Spouse Eligible Adult is the court-appointed legal guardian.

Section 2.16 Employee. Any individual who is employed by the Employer, but excluding (a) an individual who has been classified by the Employer as an independent contractor, notwithstanding a later contrary determination by any court or governmental agency, (b) "leased employees" within the meaning of Code Section 414(n), except to the extent required by Code Sections 125 and 414(n), (c) nonresident aliens with no income from sources within the United States, (d) "self-employed individuals" under Code Section 401(c), and (e) union employees who are members of a collective bargaining unit that has bargained in good faith over benefits substantially similar to those available under the Plan and whose participation is not provided for under such agreement. Such term includes "former Employees" for the limited purpose of allowing continued eligibility for Optional Benefit Programs provided hereunder for the remainder of the Plan Year or Period of Coverage in which an Employee ceases to be employed by the Employer. However, former Employees are entitled to continued eligibility during a period when they are receiving severance benefits but only for the maximum period of time permissible under the severance pay plan included herein, even if the former Employee is receiving severance benefits under a plan or policy other than the one incorporated herein.

Section 2.17 Employer. The Plan Sponsor and any Affiliated Employer electing to participate in this Plan with the consent of the Administrator; provided, however, that where power is reserved hereunder to the Employer, such term shall mean only the Plan Sponsor. Participating Employers that adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation. Participating Employers may be required by the Plan Sponsor to execute a participation agreement to confirm the terms of their participation in the Plan from time to time. Affiliated Employers that are consolidated with the Employer for financial statement reporting purposes are participating Employers except as set forth in Appendix C or an Incorporated Document.

Section 2.18 Entry Date. Except as otherwise provided in an Incorporated Document, the following dates for the following purposes:

- A. For purposes of the Premium Conversion Program, the date or dates on which the Employee satisfies the eligibility requirements of Article III. For purposes of the Health Care Flexible Spending Account Program, the Dependent Care Flexible Spending Account Program, the HSA Program and the HRA Program, the first day on which the Employee satisfies the eligibility requirements of Article III and the first day of each subsequent Period of Coverage.
- C. For purposes of any other Benefits provided under the Plan on a non-elective basis or outside of the Optional Benefit Programs, the date or dates on which the Employee satisfies the eligibility requirements of Article III.

Section 2.19 ERISA. The Employee Retirement Income Security Act of 1974, as amended from time to time.

Section 2.20 FMLA. The Family and Medical Leave Act of 1993, as amended from time to time.

Section 2.21 Health Care Flexible Spending Account Program. The Optional Benefit Program established under Article V for the reimbursement of Eligible Medical Expenses. The Employer may, in its discretion, determine during which periods of time it will and will not offer the Health Care Flexible Spending Account Program to otherwise eligible Employees.

Section 2.22 Health Reimbursement Account Program or HRA Program. The Benefit established under Article V of the Plan for the reimbursement of Eligible Medical Expenses, as amended from time to time. The Employer may, in its discretion, determine during which periods of time it will and will not offer the HRA Program to otherwise eligible Employees.

Section 2.23 Health Savings Account or HSA. A Participant's health savings account that satisfies the requirements of Code Section 223 and the Regulations thereunder. A Health Savings Account is an individual trust or custodial account arrangement that is established and maintained by a Participant with a qualified trustee or custodian, respectively, outside of the Plan.

Section 2.24 Health Savings Account Program or HSA Program. The Optional Benefit Program whereby an HSA-Eligible Employee may elect to make pre-tax Contributions to his HSA. The HSA Program is not intended to constitute an "employee welfare benefit plan," as defined in ERISA and the Plan shall be operated and interpreted in a manner consistent with this intent. Notwithstanding the preceding, the Employer may limit the qualified trustee(s) and/or custodian(s) to whom it will forward Contributions under the HSA Program.

Section 2.25 Highly Compensated Individual. Solely for the purposes of applying the requirements of Code Section 125(b)(1)(A), a Highly Compensated Individual is an eligible Employee who is a highly compensated individual as defined in Code Section 125(e)(2), including officers, shareholders owning more than five percent of the voting power or value of all classes of stock of the Employer, if any, individuals who are otherwise considered highly compensated by the Internal Revenue Service for purposes of this Plan only, and spouses or dependents (within the meaning of Code Section 152, determined without regard to Subsections (b)(1), (b)(2) and (d)(1)(B) thereof) of any individuals previously described.

Section 2.26 Highly Compensated Participant. A Highly Compensated Individual who elects to participate in the Plan.

Section 2.27 HIPAA. The Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Section 2.28 HSA-Eligible Employee. An Employee who is eligible to contribute to an HSA under Code Section 223 and the Regulations thereunder, has established an HSA with a qualified trustee or custodian, and elects coverage under a high deductible health plan Benefit.

Section 2.29 Incorporated Documents. Each insurance contract under which Benefits that are fully insured are provided, and each Summary Plan Description ("SPD") or other summary or similar document that relates to and describes any Benefit(s) or Optional Benefit Program provided under the Plan.

Section 2.30 Key Employee. Any person who is a key employee as defined in Code Section 416(i).

Section 2.31 Non-Spouse Eligible Adult. A Non-Spouse Eligible Adult is a person who satisfies all of the following criteria:

- A. The person is not the eligible Employee's legal Spouse;
- B. The person shares the eligible Employee's permanent residence;
- C. The person is financially interdependent with the eligible Employee;
- D. The person is not legally married to someone other than the eligible Employee; and
- E. The person is not the eligible Employee's:
 - 1. Parent/Step-parent;
 - 2. Parent's/Step-parent's other descendants (i.e., the Employee's siblings, nieces, nephews);
 - 3. Grandparent's/Step-Grandparent's and their descendants (e.g., the Employee's aunt, uncle, cousin, etc.);
 - 4. In-law;
 - 5. Renter, boarder, tenant, or employee; or
 - 6. Child or grandchild.

The Administrator shall have the sole discretion to determine whether a person satisfies the requirements to be an Employee's Non-Spouse Eligible Adult.

Section 2.32 Optional Benefit Programs. The Benefits and programs made available to a Participant by the Employer from time to time under the Premium Conversion Program, the Health Care Flexible Spending Account Program, the Dependent Care Flexible Spending Account Program and the HSA Program.

Section 2.33 Participant. Any eligible Employee who has satisfied the applicable eligibility and participation conditions of Article III and participates in one or more of the Benefits or Optional Benefit Programs, including any individual defined as a "Participant" in an Incorporated Document. To the extent required under the terms of any Optional Benefit Program offered through the Plan, a person who is eligible to and elects to continue to participate in such Optional Benefit Program subsequent to the termination of his or her participation in the Plan shall be considered a Participant in the Optional Benefit Program in which he or she continues to participate, and may continue to receive such Benefits, but shall not otherwise be considered a Participant in the Plan or any other Optional Benefit Program.

Section 2.34 Period Of Coverage. The twelve consecutive month period during which Benefits are provided under the Plan to Participants and Dependents except: (a) for eligible Employees who first become Participants and eligible Dependents who first become covered

under the Plan during a Period of Coverage, the portion of the 12 consecutive month Period of Coverage following the date participation or coverage commences; and (b) for Participants and Dependents who terminate participation, the portion of the 12 consecutive month Period of Coverage prior to the date participation terminates.

Section 2.35 Plan. The CHE Trinity Welfare Benefit Plan, formerly known as the Trinity Health Corporation Welfare Benefit Plan, as described herein, and as amended from time to time. The Plan is comprised of two separate plans: Plan 504 and Plan 505. All references to the "Plan" shall be to both plans, unless otherwise provided herein.

Section 2.36 Plan 504. One of the two separate plans which make up the Plan. Plan 504 is comprised of the benefits listed on Appendix A and consists of all of the medical programs as well as the other health benefit programs provided by the Employer.

Section 2.37 Plan 505. One of the two separate plans which make up the Plan. Plan 505 is comprised of the benefits listed on Appendix B and consists of the programs, other than the medical programs, provided under the Plan.

Section 2.38 Plan Sponsor. Trinity Health Corporation, an Indiana non-profit corporation.

Section 2.39 Plan Year. The twelve consecutive month calendar year beginning on each January 1 and ending on December 31 of each year.

Section 2.40 Premium Conversion Program. The Optional Benefit Program established under Article V that permits a Participant to elect to participate in certain Benefit programs listed in Appendices A and B, as specified by the Employer from time to time, other than the Health Care Flexible Spending Account Program and the Dependent Care Flexible Spending Account Program.

Section 2.41 Regulations. The Treasury Regulations and other guidance promulgated under the Code.

Section 2.42 Spouse. Except as otherwise provided in an Incorporated Document, the legally married husband or wife of an Employee under applicable law. For purposes of this Section, applicable law shall be the state law applicable to the administration of the Plan. A spouse by common law marriage is not considered a Spouse for Plan purposes.

Section 2.43 Tax Dependent. For Plan purposes: (a) an Employee's spouse as recognized as a dependent under the Code, (b) except as otherwise provided in an Incorporated Document, an Employee's Dependent who is the Employee's biological child, stepchild, legally adopted child, eligible foster child (as defined in Code Section 152(f)(1)(C)) or child lawfully placed with the Employee for legal adoption by the Employee who, as of the end of the applicable Plan Year, has not attained age 27, and (c) an Employee's Dependent who is the Employee's dependent within the meaning of Code Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) for purposes of accident and health benefits under Code Sections 105 and 106.

Section 2.44 Trinity Health. Trinity Health Corporation, an Indiana non-profit corporation, or any successor thereto.

Section 2.45 Uniformed Service. Qualified military service, as defined in Code Section 414(u)(5).

Section 2.46 USERRA. The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended by the Veterans Benefits Improvement Act of 2004.

Section 2.47 Terms Defined Elsewhere.

Claim	Section 6.13.A.1
COBRA Continuation Coverage	Section 3.8
Covered Employee	Section 3.8.A.1
Dependent	Sections 5.3.A.1 and 5.4.A.1, 5.5.B.1
Dependent Care Account	Section 5.4.A.2
Earned Income.....	Section 5.4.A.4
Eligible Dependent Care Expenses	Section 5.4.A.3
Eligible Medical Expenses	Sections 5.3.A.2 and 5.5.B.2
Employee.....	Section 3.8
Health Care Expense Account	Section 5.3.A.3
Health Reimbursement Account or HRA	Section 5.5.B.3
Highly Compensated Individual	Sections 5.3.A.4, 5.4.A.5 and 5.5.B.4
Hybrid Entity	Section 6.17
Limited-Purpose Health Reimbursement Account or Limited-Purpose HRA	Section 5.5.B.5
Limited-Purpose HRA-Eligible Participant	Section 5.5.B.6
Medical Benefit Claim	Section 6.13.A.2
Period of Coverage	Section 5.3.A.5
Post-Service Claim	Section 6.13.A.3
Pre-Service Claim	Section 6.13.A.4
Qualified Beneficiary	Section 3.8.A
Qualified Change in Status	Section 4.5
Qualified Medical Child Support Order	Section 8.1
Qualifying Events	Section 3.8.B
Relevant.....	Section 6.13.A.5
Urgent Care Claim	Section 6.13.A.6

ARTICLE III

ELIGIBILITY AND PARTICIPATION

Section 3.1 Eligible Employees. An Employee who is in an eligible group of Employees under the eligibility requirements of one or more Benefit programs or Optional Benefit Programs, as specified in the applicable Incorporated Document(s), shall be eligible to participate in the Benefits under the Plan for which he or she is eligible.

Section 3.2 Conditions For Participation. Employees who are eligible to participate in the Plan may elect to participate by enrolling in the Plan (or each applicable Benefit or Optional Benefit Program) under Article IV in accordance with procedures established by the Administrator from time to time and after satisfaction of any waiting periods or other eligibility requirements, if any, specified in the applicable Incorporated Document. If participation requirements are not provided in any Incorporated Document for a Benefit, an Employee generally shall be eligible to participate in the Plan with respect to that Benefit as of the Employee's date of hire with the Employer. Certain Benefit programs are automatically provided to Employees, and no enrollment is required subject to satisfaction of waiting periods or eligibility requirements, if any, specified in the applicable Incorporated Document.

Section 3.3 Effective Date Of Participation. An Employee who is eligible and who elects to participate in one or more Benefits offered under the Plan in accordance with Article IV shall become a Participant effective as of the Entry Date coincident with or next following the eligible Employee's election of those Benefits requiring such an election. The Administrator may establish uniform rules or policies that require elections to be made within certain time periods. If a Benefit offered under the Plan does not require an eligible Employee to make an election to participate, an Employee who satisfies the conditions for participation shall become a Participant with respect to such Benefit effective as of the Entry Date.

Section 3.4 Participation During Leave of Absence. Subject to any specific limitations for any particular Benefit or Optional Benefit Program:

- A. A Participant who is not at work with an Employer due to an unpaid FMLA leave, an unpaid period of Uniformed Service lasting more than 31 days, an unpaid leave pursuant to the Employer's policies, or any other reason that creates a legal obligation for the Employer to extend certain Benefit coverage, may, at the Participant's option, and subject to any specific limitation for any specific Benefit or Optional Benefit Program, continue during the period of absence any or all Benefits under the Plan that the Participant was receiving at the date the absence commenced, provided the Participant continues to make any required Contributions. During an unpaid absence, a Participant may choose to make Contributions by:
1. Remitting payment to the Employer on or before each pay period for which the Contributions would have been deducted from the Participant's paycheck if an unpaid leave had not been taken, provided that any delinquent payment must be made within 30 days of its due date;
 2. If the Employer permits, prepaying the amounts that will become due during the unpaid leave out of one or more of the Participant's paychecks preceding the leave; or

3. If the Employer permits, repaying the amounts that became due during the unpaid leave out of one or more of the Participant's paychecks following the Participant's return to work.

B. A Participant who is absent from work with an Employer for any approved paid leave of absence must continue any and all Benefits elected under this Plan, and Participant Contributions (if any) for those Benefits will continue to be deducted from the Participant's paychecks during the absence.

Section 3.5 Coverage During FMLA Leave. Notwithstanding any provision to the contrary in the Plan, if a Participant is granted a qualifying unpaid leave under the FMLA, to the extent required by the FMLA, the Employer will continue to maintain the Participant's benefits under any "group health plan" as defined in Code Section 5000(b)(1) on the same terms and conditions as though he or she were still an active Employee (i.e., the Employer will continue to pay its share of the premium to the extent the Participant elects to continue his or her coverage). If the Participant elects to continue his or her coverage, the Participant may pay his or her share of the premium with after-tax dollars while on leave (or pre-tax dollars to the extent the Participant receives Compensation during the leave), or the Participant may be given the option to prepay all or a portion of the Participant's share of the premium for the anticipated duration of the leave on a pre-tax salary reduction out of the Participant's pre-leave Compensation by making a special election to that effect prior to the date such Compensation normally would be made available to him or her (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next year), or through other arrangements agreed upon by the Participant and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold amounts upon the Participant's return). Upon return from such leave, the Participant will be permitted to reenter the Plan on the same basis the Participant was participating prior to taking leave, or as otherwise required by the FMLA, and shall have whatever rights as shall be applicable under this Plan and applicable law.

Section 3.6 Rehired Employees. If an Employee terminates employment and is subsequently reemployed by the Employer, the Employee shall become a Participant as provided in the Incorporated Documents. If an Incorporated Document does not contain any rules for participation on reemployment, the following rules shall apply:

A. If an eligible Employee terminates employment prior to becoming a Participant and is subsequently reemployed by the Employer, the Employee must satisfy the eligibility requirements in order to participate in the Plan without regard to any prior period of employment with the Employer.

B. If an Employee terminates employment after becoming a Participant and is subsequently reemployed by the Employer within 30 or fewer days from the date the Participant terminated employment, the former Participant shall automatically participate immediately in the Plan upon reemployment, in the same Benefits and Optional Benefit Programs and at the same level of coverage as in effect before the Participant's termination of employment, unless a change is otherwise permitted due to a Qualified Change in Status.

C. If an Employee terminates employment after becoming a Participant and subsequently becomes reemployed with the Employer more than 30 days from the date the Participant terminated employment, the former Participant may participate in the Plan again upon reemployment when the Employee again

meets the requirements of this Article III without regard to any prior period of employment with the Employer.

Section 3.7 Termination of Participation.

- A. Except as otherwise provided in an Incorporated Document, a Participant shall cease to be a Participant in each Benefit as of the earliest of:
1. The date the Participant is no longer an Employee eligible to participate in the Plan (or the applicable Benefit or Optional Benefit Program) under this Article III (including termination of employment);
 2. The date of termination of the Plan;
 3. The date of termination of the program providing the Benefit or the Optional Benefit Program;
 4. The date the Participant elects to terminate participation in one or more Optional Benefit Programs pursuant to the rules of Article IV; or
 5. The date of the Participant's death.

Termination of participation in this Plan shall not affect a former Participant's entitlement to continued Benefits or coverage under an Optional Benefit Program or the HRA Program if and to the extent required by such Benefit, as described in any Incorporated Document, under an Optional Benefit Program or the HRA Program, or under applicable state or federal law. Except as otherwise provided in an Incorporated Document, if a Participant ceases to make the required Contributions under the Plan, other than as contemplated in connection with certain leaves of absence, then such Participant shall cease to be a Participant in the Plan and may not participate in the Plan for the remainder of such applicable Period of Coverage.

- B. Except as otherwise provided in an Incorporated Document, a Dependent shall cease to be covered under each Benefit as of the earliest of:
1. The date the Participant with respect to whom the individual is a Dependent ceases to be a Participant;
 2. The date the individual ceases to be a Dependent; or
 3. The date the Participant elects to terminate the Dependent's coverage pursuant to the rules of Article IV.

Section 3.8 COBRA Continuation Coverage. Except as otherwise provided herein, each person who is a Qualified Beneficiary shall have the right to elect to continue coverage under any applicable Benefit or Optional Benefit Program that is considered to be a "health plan" and subject to the requirements of Code Section 4980B, ERISA Sections 601, et seq., or 42 U.S.C. Section 300bb (collectively referred to as "COBRA"), upon the occurrence of a Qualifying Event. Each Qualified Beneficiary must be offered a group health benefit that is the same as the coverage offered to similarly situated Covered Employees, their Spouses and

Dependents. This coverage is known as "COBRA Continuation Coverage". For purposes of this Section, "Employee" is defined as any individual who is eligible to be covered under a group health benefit program by virtue of the performance of services for an Employer maintaining the Plan.

A. **Qualified Beneficiary.** A Qualified Beneficiary is any person who, as of the day before a Qualifying Event, is:

1. An individual covered under the applicable Benefit by virtue of being on that day either a Covered Employee, the Spouse of a Covered Employee or another Dependent of a Covered Employee. A Covered Employee's Non-Spouse Eligible Adult who is not recognized as the Covered Employee's spouse under the Code and such Non-Spouse Eligible Adult's children are not Qualified Beneficiaries even if they are covered under the applicable Benefit on the day before a Qualifying Event by virtue of being the Covered Employee's Dependents. A "**Covered Employee**" is generally any individual who is (or was) provided coverage under a group health benefit program by virtue of being or having been an Employee. A Covered Employee can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (for any reason other than gross misconduct) or reduction of hours of the Covered Employee's employment or the bankruptcy of the Employer; or
2. A child who is born to or placed for adoption with a Covered Employee during a period of COBRA Continuation Coverage.

A Qualified Beneficiary shall have the same rights as a Covered Employee to enroll individuals (e.g., newborn children, adopted children or a new Spouse) at times other than open enrollment periods.

B. **Qualifying Events.** Any of the following shall be considered as a Qualifying Event, provided a Qualified Beneficiary will "lose coverage" under the applicable group health Benefit program as a result thereof. To "lose coverage" generally means to cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event. Qualifying Events include:

1. The termination (other than by reason of gross misconduct) of the Covered Employee's employment or reduction of hours of employment below any minimum level of hours required for participation in the applicable Benefit program;
2. The death of a Covered Employee;
3. The divorce or legal separation of a Covered Employee from the Covered Employee's Spouse;
4. The Covered Employee's becoming entitled to receive Medicare benefits under Title XVIII of the Social Security Act;
5. A Dependent child of a Covered Employee ceasing to be a Dependent; or

6. Certain bankruptcy proceedings under Title 11 of the United States Code.

- C. Notification Requirements. Within 30 days of the occurrence of a Qualifying Event under paragraph B.1., B.2., B.4. or B.6., above, the Employer shall notify the Administrator of such Qualifying Event. Within 14 days of such notification, the Administrator shall furnish each Qualified Beneficiary written notification of the termination of coverage under the applicable Benefit program, as well as the right to elect COBRA Continuation Coverage, if applicable.

For Qualifying Events described in paragraph B.3. and B.5., above, a Covered Employee or other Qualified Beneficiary must notify the Administrator in writing within 60 days of the occurrence of such Qualifying Event. Within 14 days of its receipt of such notice, the Administrator shall furnish each Qualified Beneficiary written notification of the right to elect COBRA Continuation Coverage. If a Covered Employee or Qualified Beneficiary fails to notify the Administrator within this 60-day period of such Qualifying Event, he or she shall be deemed to have waived the right to elect COBRA Continuation Coverage, if applicable.

In all cases, notification to a Qualified Beneficiary who is a Covered Employee or a Spouse of a Covered Employee is treated as notification to all other Qualified Beneficiaries residing with that Qualified Beneficiary at the time notification is made. In addition, the Administrator may delegate the notice responsibilities to others, such as a third party administrator, provided affected Qualified Beneficiaries are informed to whom notice must be given.

- D. Election Period. A Qualified Beneficiary entitled to elect COBRA Continuation Coverage must return a signed election of COBRA Continuation Coverage to the Employer within 60 days of the later of the following dates:
1. The date upon which the Qualified Beneficiary is sent notice of his or her right to elect COBRA Continuation Coverage; or
 2. The date upon which the Qualified Beneficiary's coverage under the applicable Benefit program terminates.

A Qualified Beneficiary who does not elect COBRA Continuation Coverage in connection with a Qualifying Event within 60 days of such event ceases to be a Qualified Beneficiary at the end of the election period.

- E. Multiple Qualifying Events. Subject to paragraphs F. and G. below, for Qualifying Events under paragraph B.1., COBRA Continuation Coverage may extend for a maximum period of up to 18 months after the date of the Qualifying Event, unless, during such 18-month period, a subsequent Qualifying Event occurs. If a second Qualifying Event occurs during the 18-month period, then another election to extend coverage for up to 18 additional months may be available to the Qualified Beneficiary. In no event, however, shall COBRA Continuation Coverage extend more than 36 months beyond the date of the first Qualifying Event. For all other Qualifying Events under paragraph B., COBRA Continuation Coverage may extend for a maximum period of up to 36 months after the date of the Qualifying Event.

- F. Disability. If any Qualifying Event is the Employee's termination or reduction in hours of employment and a Qualified Beneficiary is disabled within the meaning of Title II or XVI of the Social Security Act at any time during the first 60 days after COBRA Continuation Coverage begins, then the 18-month coverage period will be extended for up to a total of 29 months, provided the disabled individual complies with the following notice requirements. In order to receive this extension of COBRA Continuation Coverage, the disabled individual must notify the Administrator of the determination of disability under Title II or XVI of the Social Security Act within the original 18-month coverage period and within 60 days after the latest of: (1) the date such determination is made, (2) the date on which the Qualifying Event occurs, or (3) the date on which the Qualified Beneficiary loses (or would lose) coverage as a result of the Qualifying Event.
- G. Termination of COBRA Continuation Coverage. For each Qualified Beneficiary electing COBRA Continuation Coverage, such coverage shall automatically cease upon the occurrence of any of the following events:
1. The Employer no longer offers the applicable Benefit or any similar Benefit of the same type to any of its Employees;
 2. The required premium for COBRA Continuation Coverage is not paid within 30 days of the date such premium is due;
 3. Such Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to pre-existing conditions, if applicable;
 4. Such Qualified Beneficiary becomes covered and is entitled to receive benefits under Medicare;
 5. In the event a Qualified Beneficiary is receiving extended COBRA Continuation Coverage as a result of being disabled under the Social Security Act, such individual must notify the Administrator within 30 days of the date of any final determination under the Social Security Act that he is no longer disabled. The extended COBRA Continuation Coverage may then be terminated after more than 30 days has passed from the date of this final determination, provided that the end of the maximum coverage period that exists without respect to the disability has not expired; or
 6. Reasons that could result in the termination of coverage under the Plan or Benefit program for active Employees and their Dependents, such as fraud.

In addition, in the event of the bankruptcy of the Employer, certain other time periods apply, as described in Code Section 4980B and the underlying Regulations.

- H. Payment of COBRA Continuation Coverage Premiums. The cost of COBRA Continuation Coverage premiums shall generally be paid entirely by the Qualified Beneficiary and the Employer shall not pay for or subsidize the cost of COBRA Continuation Coverage except as otherwise provided under the Incorporated

Documents of an applicable Benefit or Optional Benefit Program or other contractual obligation. The premium cost for COBRA Continuation Coverage shall equal the full cost to the Plan for such period of coverage for similarly situated Covered Employees, Spouses or other Dependents, for whom a Qualifying Event has not occurred. Except as provided below, a Qualified Beneficiary must also pay an administration fee equal to two percent (2%) of the premium cost of COBRA Continuation Coverage for expenses incurred in administering COBRA Continuation Coverage. If a Qualified Beneficiary has elected to extend his or her COBRA Continuation Coverage pursuant to paragraph F. of this Section as a result of disability, then the administration fee shall be equal to 50% of the cost of COBRA Continuation Coverage for the 11-month extension that occurs after the original 18-month period, or such longer period as may be available due to the occurrence of another Qualifying Event during the disability extension period.

A Qualified Beneficiary's initial premium payment following the election of COBRA Continuation Coverage is considered timely if received within 45 days of a timely COBRA Continuation Coverage election. Premium payments for COBRA Continuation Coverage shall be due and payable on the first of each calendar month for which COBRA Continuation Coverage is desired. Notwithstanding the foregoing, premium payments will be considered timely if they are made within 30 days of the premium payment due date. In addition, if a timely payment is made to the Plan, but such payment is short by the lesser of \$50 or 10% of the premium payment amount, the Plan must treat such payment as a full payment unless the Plan notifies the Qualified Beneficiary of the amount that is deficient and grants a minimum of 30 days for the Qualified Beneficiary to make up such deficiency.

- I. FMLA Leave and COBRA Continuation Coverage. COBRA Continuation Coverage is not triggered when a Participant takes FMLA leave. A Qualifying Event will occur, however, if an Employee (or Spouse or Dependent of the Employee) is covered by a group health Benefit program on the day before the first day of FMLA leave, the Employee does not return to work at the end of FMLA leave and, in the absence of the election of COBRA Continuation Coverage, the Employee (or Spouse or Dependent) would lose coverage under the group health Benefit program before the time that would be the maximum coverage period. The Qualifying Event will be deemed to occur on the last day of FMLA leave. If a lapse in group health Benefit coverage occurs during the period of FMLA leave because the Employee fails to pay the required premium amount or declines coverage, this fact does not affect whether a Qualifying Event occurs or when such event occurs.

- J. Coverage Interpretation. The provisions of this Section are to be interpreted in conformity with Code Section 4980B, ERISA Sections 601 et seq., and/or the Public Health Service Act (42 U.S.C. Section 300bb), as applicable, and the Regulations promulgated thereunder. The Plan does not intend to provide COBRA Continuation Coverage beyond the federal law requirements. The Administrator reserves the right to reject at any time any attempted election of COBRA Continuation Coverage, if the Participant or his or her Spouse or other Dependent is not entitled to such coverage. This rejection may take place on a retroactive basis, even if the Employer previously accepted payment from the

Participant or his or her Spouse or other Dependent of one or more premiums for COBRA Continuation Coverage.

Section 3.9 COBRA Continuation Coverage under Health Care Flexible Spending Account Program. Notwithstanding any Plan provisions herein to the contrary, with regard to the Health Care Flexible Spending Account Program, a Qualified Beneficiary will be eligible to elect COBRA Continuation Coverage under the Health Care Flexible Spending Account Program only if the Participant's Health Care Expense Account balance at the time of the Qualifying Event exceeds the amount of COBRA premiums required to maintain coverage under the Health Care Flexible Spending Account Program for the balance of the Plan Year in which the Qualifying Event occurs. If a Qualified Beneficiary is eligible to elect COBRA Continuation Coverage under the Health Care Flexible Spending Account Program, such COBRA Continuation Coverage shall be available only until the end of the Plan Year in which the Qualifying Event occurs.

Section 3.10 COBRA Premiums While Receiving Severance Pay. Subject to and in conformance to the rules established under Code Section 125 and the Regulations thereunder, the Administrator may elect to withhold COBRA premiums be paid out of severance benefits received by former Employees.

Section 3.11 USERRA Continuation of Coverage. Notwithstanding any Plan provisions herein to the contrary, with regard to each Benefit made available under the Plan that is considered to be a "health plan" (as defined in Section 38 U.S.C. Section 4303(7)), a Participant who performs service in the Uniformed Services may elect continuation of coverage under the Plan as required by USERRA.

Section 3.12 Change of Employment Status. If a Participant has not terminated employment with the Employer but becomes an Employee who is not eligible to participate in this Plan because of a change in employment status or classification, the individual shall become an inactive Participant in this Plan. As an inactive Participant, Contributions on behalf of the Participant shall cease and no further Agreements may be entered into, subject to the inactive Participant's right to continued coverage under a Benefit or an Optional Benefit Program for the balance of the Plan Year, Period of Coverage, or such other period as may apply, in accordance with that Benefit or Optional Benefit Program and the requirements of applicable law. In addition, any balance remaining of an inactive Participant's Contributions may be applied as directed during the remainder of the Plan Year (or Period of Coverage, if applicable) unless the Participant terminates participation upon becoming inactive. If an inactive Participant again becomes an eligible Employee and satisfies the eligibility requirements of Article III, the inactive Participant may become a full Participant in this Plan.

Section 3.13 Pre-existing Conditions. Except as provided in this Section, any Benefit may be subject to a pre-existing condition exclusion or limitation as further described in the applicable Incorporated Document(s). Effective January 1, 2014, a Benefit that is a group health plan shall in no event apply a pre-existing condition limitation to any Employee, Participant or Dependent.

Section 3.14 Certificates of Coverage. The Administrator (or an appropriately authorized designee) shall provide each terminating Participant with a Certificate of Coverage, certifying the period of time the individual was covered under any applicable Benefit subject to HIPAA's portability requirements. For Participants with Dependent coverage, the certificate

provided shall include information on all covered Dependents and shall separately state any information that is not identical for the Participant or any Dependent. The Plan will comply with the portability and nondiscrimination provisions of HIPAA as long as such provisions remain applicable to the Plan.

ARTICLE IV

ELECTION PROCEDURE

Section 4.1 New Participants. As soon as practicable after an eligible Employee satisfies the eligibility requirements of Article III, such Employee shall be offered the opportunity to enroll in the Plan by completing the Agreement procedures established by the Administrator. An eligible Employee who desires to elect Benefits or coverage under an Optional Benefit Program, to the extent eligible, for a Period of Coverage shall so specify on an enrollment Agreement. In addition, an eligible Employee who desires to have Contributions allocated toward the purchase of Benefits or coverage under an Optional Benefit Program, to the extent eligible, for the Period of Coverage shall so specify and shall agree to a reduction in Compensation, if applicable, or to remit after-tax Contributions, if applicable.

Employee Contributions for elected Benefits or toward the purchase of coverage under an Optional Benefit Program, other than Contributions for the Benefits elected for an Employee's Dependent who is not the Employee's Tax Dependent, will be made on a pre-tax basis unless otherwise permitted and elected by the Employee. Employee Contributions allocated toward the purchase of Benefits for an Employee's Dependent who is not the Employee's Tax Dependent or for coverage other than under an Optional Benefit Program will be made on an after-tax basis unless otherwise permitted and elected by the Employee. Elections under this Section will be effective for the entire Period of Coverage subject to the change in status rules set forth in this Article.

The enrollment requirements must be completed on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the contributions will be made. If an eligible Employee fails complete the enrollment procedures on or before the specified due date, except with respect to any Benefit that does not require an election by an Employee in order for the Employee to participate, such Employee shall be deemed to have elected not to participate in the Plan or in any applicable Benefit or Optional Benefit Program offered through the Plan for the Period of Coverage for which the Employee is eligible, unless otherwise provided by the Administrator. Notwithstanding the foregoing, if an eligible Employee completes the enrollment procedures within 30 days after his or her date of hire by the Employer, the effective date of his or her elected Benefits shall be the later of his or her date of hire or the date the Employee becomes an eligible Employee.

Section 4.2 Annual Election and Agreement Procedure. During an annual Election Period, the Administrator shall make the Agreement procedures available to each Participant and each other eligible Employee who has satisfied the requirements of Article III. Each such Employee and Participant who desires to elect Benefits or coverage under an Optional Benefit Program, to the extent eligible, for the next following Period of Coverage will so specify in accordance with the Agreement procedures. In addition, an eligible Employee who desires to have Contributions allocated toward the purchase of Benefits or coverage under one or more Optional Benefit Programs, to the extent applicable, for the next following Period of Coverage shall so specify in accordance with the Agreement procedures and shall agree to a reduction in Compensation, if applicable.

Employee Contributions for coverage under an Optional Benefit Program, other than Benefits for an Employee's Dependent who is not the Employee's Tax Dependent, will be made on a pre-tax basis unless otherwise permitted and elected by the Employee. Employee

Contributions for Benefits other than under an Optional Benefit Program and for an Employee's Dependent who is not the Employee's Tax Dependent will be made on an after-tax basis.

Elections under this Section will be effective for the entire Period of Coverage next following the Election Period and may provide for different or additional options or elections than were in effect for the prior Period of Coverage. In addition, a Participant may elect to terminate participation in some or all Benefits or Optional Benefit Programs under the Plan for the next Period of Coverage by so indicating to the Employer in writing during the Election Period.

Section 4.3 Election Form and Timing. Elections must be made in accordance with procedures established by the Administrator, and shall specify the Benefit(s) and/or Optional Benefit Program(s) to which Contributions shall be allocated. Eligible Employees and Participants may be required to complete the Agreement procedures via telephone or voice response technology, electronic communication (e.g., on-line enrollment), or any other method prescribed by the Administrator. Except as provided for new Participants, a Participant's election under the Plan pursuant to the Agreement procedures shall be effective with the first regularly scheduled pay period of the Period of Coverage for which the Participant's election under the Plan is made. The Agreement procedures must be completed on or before the last day of the Election Period or such other date as the Administrator shall specify, which date shall be no later than the day prior to the first day of the Period of Coverage for annual elections. Election procedures completed on and after the first day of the Period of Coverage will generally be void.

Section 4.4 Participant Failure to Elect. The Administrator may implement rules or otherwise notify eligible Employees who fail to complete the Agreement procedures on or before the specified due date whether such failure shall be deemed to be an election to continue the same elections as are currently in effect for the new Period of Coverage or be deemed an election not to participate in one or more Benefits. An eligible Employee or Participant who fails to complete the Agreement procedures on or before the due date shall be deemed to have elected to (A) discontinue any election then in effect as to the Dependent Care Flexible Spending Account Program or the Health Care Flexible Spending Account Program and to receive the remainder of the Employee's Compensation as salary or wages, and (B) unless otherwise notified by the Employer, continue any election then in effect as to any other Benefit program, or if no election is then in effect, to receive the remainder of the Employee's Compensation as salary or wages. Further, in the event that an Employee fails to complete the Agreement procedures, the Employer may set default elections for such Employees, as specified in any notifications accompanying the enrollment materials. Unless specified otherwise by the Employer, if the Benefit program elected by the Participant for the preceding Period of Coverage is no longer available, the Participant shall be deemed to have elected the Benefit program most comparable to the option previously in effect or such other option as communicated by the Employer. The Participant shall also be deemed to have agreed to a reduction in his or her Compensation for the subsequent Period of Coverage equal to the Participant's share of the cost from time to time during such Period of Coverage of all Benefit programs he or she is deemed to have elected for such Period of Coverage.

Section 4.5 Qualified Change in Status. Elections made under the Plan for Optional Benefit Programs (other than the HSA Program), including Benefits for an Employee's Dependent who is not the Employee's Tax Dependent, are irrevocable throughout a Period of Coverage unless the Participant has a Qualified Change in Status. Except as otherwise provided under any Optional Benefit Program, a Participant may revoke an election for the balance of a Period of Coverage and make a new election only if both the revocation and the

new election are due to and consistent with a Qualified Change in Status. For this purpose, a "Qualified Change in Status" is one of the following:

- A. Marital Status. An event that changes the Employee's legal marital status, such as:
 - 1. Marriage;
 - 2. Divorce;
 - 3. Legal separation;
 - 4. Annulment; or the
 - 5. Death of the Employee's Spouse;

- B. Number of Dependents. An event that changes the number of the Employee's Dependents, such as:
 - 1. Birth;
 - 2. Death;
 - 3. Adoption;
 - 4. Placement for adoption; or
 - 5. A change in the number of qualifying individuals as defined in Code Section 21(b)(1) for purposes of the Dependent Care Flexible Spending Account Program only;

- C. Employment Status. An event that changes the employment status of the Employee, the Employee's Spouse or Dependent (other than an Employee's Non-Spouse Eligible Adult who is not the Employee's Tax Dependent and such Non-Spouse Eligible Adult's children who are not also the Employee's children) such that the event causes the Employee, the Employee's Spouse or Dependent to either gain or lose eligibility for an employer's benefit program, such as:
 - 1. The commencement or termination of employment;
 - 2. A strike or lockout;
 - 3. The commencement or termination of an unpaid leave of absence;
 - 4. A change in work site location that removes the affected individual from a benefit plan's service provider area; or
 - 5. Any employment status change that affects the eligibility of the individual to participate in a benefit program or plan of an employer, including a change from full-time to part-time, hourly to salaried, union to non-union status, or the reverse of any such change;

- D. Residence. A change in the residence of the Employee, the Employee's Spouse or Dependent (other than an Employee's Non-Spouse Eligible Adult who is not the Employee's Tax Dependent and such Non-Spouse Eligible Adult's children who are not also the Employee's children) that affects eligibility for coverage (provided, however, that such a change entitles the Employee only to select another coverage option, but may not permit the Employee to opt out of coverage entirely unless, as a result of the move, the Employee is no longer eligible for coverage);
- E. Dependent Eligibility. A change that causes a Participant's Dependent to satisfy or cease to satisfy the eligibility requirements to participate in an employer's benefit plan, including:
1. The attainment of majority age;
 2. Gaining or losing student status, if applicable; or
 3. A change in plan eligibility requirements;
- F. Cost or Coverage. A significant change in the cost or coverage of a benefit plan offered to the Employee, the Employee's Spouse or Dependent (other than an Employee's Non-Spouse Eligible Adult who is not the Employee's Tax Dependent and such Non-Spouse Eligible Adult's children who are not also the Employee's children), such as:
1. A new benefit option being added;
 2. A benefit option being eliminated or significantly curtailed;
 3. A coverage change made under a plan offered by the employer of the Employee's Spouse, former Spouse or other Dependent (other than an Employee's Non-Spouse Eligible Adult who is not the Employee's Tax Dependent and such Non-Spouse Eligible Adult's children who are not also the Employee's children), if the other employer's plan allows participants to make all mid-period election changes allowed under Treas. Reg. Sections 1.125-4(b) through (g), except (f)(4);
 4. A significant increase in the cost of a benefit, (such Qualified Change in Status permits the Employee to make a new benefit selection, but does not allow the Employee to revoke coverage entirely, unless no other similar coverage is available); further, in the case of the Dependent Care Flexible Spending Account Program, where the provider is a relative of the Employee, no election change is permitted for this change in status reason; or
 5. A change in dependent care provider (for purposes of elections made under the Dependent Care Flexible Spending Account Program);
- G. Medicare/Medicaid. The Employee, Employee's Spouse or Dependent (other than an Employee's Non-Spouse Eligible Adult who is not the Employee's Tax Dependent and such Non-Spouse Eligible Adult's children who are not also the

Employee's children) becoming covered or losing benefit coverage 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 for pediatric vaccines (for the purpose of elections made under any available accident or health plan as defined by Code Sections 105 and 106, the Health Care Flexible Spending Account Program and the HRA Program);

- H. COBRA. The eligibility for COBRA Continuation Coverage by the Employee, the Employee's Spouse or Dependent (other than an Employee's Non-Spouse Eligible Adult who is not recognized as the Employee's spouse under the Code and such Non-Spouse Eligible Adult's children who are not also the Employee's children; only for the purpose of allowing an election to increase any pre-tax Contributions to pay for the COBRA premium);
- I. FMLA. The Employee's commencing or returning from an unpaid leave of absence as permitted and regulated by the FMLA (as applied only to elections made under any available accident or health plan defined by Code Sections 105 and 106);
- J. Open Enrollment. An election of coverage by the Employee or the Employee's Spouse, former Spouse or other Dependent (other than an Employee's Non-Spouse Eligible Adult who is not the Employee's Tax Dependent and such Non-Spouse Eligible Adult's children who are not also the Employee's children) during an open enrollment period that differs in time from the annual enrollment period offered by the Employer; provided, however, that an Employee will not be permitted to change his or her pre-tax Contributions under the Plan due to the election of coverage by the Employee's Dependent that is not the Employee's Tax Dependent;
- K. Court Order. A duly executed judgment, decree or order (including a qualified medical child support order as defined in ERISA Section 609), resulting from a divorce, legal separation, annulment or change in legal custody that requires health coverage for the Employee's child who is a Dependent of the Employee (for the purpose of any elections made under any available accident or health plan as defined by Code Sections 105 and 106 and the Health Care Flexible Spending Account Program – coverage previously elected by the Employee may be dropped only if the other individual actually provides coverage for the child);
- L. HIPAA. A special enrollment right that the Employee or Dependent may be entitled to under the provisions of HIPAA as described in Code Section 9801(f) (for the purpose of any elections made under any available accident or health plan as defined by Code Sections 105 and 106 only, or the Health Care Flexible Spending Account Program if such Health Care Flexible Spending Account Program is subject to the provisions of HIPAA);
- M. CHIPRA. A special enrollment right that the Employee or Dependent may be entitled to under the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") authorizing mid-year enrollment if the Employee or Dependent is not enrolled in coverage under the Plan and: (i) the Employee or Dependent loses benefit coverage under Medicaid or the State Children's Health Insurance Program (CHIP), or (ii) the Employee or Dependent becomes eligible for

premium assistance subsidy offered by the State (for the purpose of any elections made under any available health plan as defined by Code Sections 105 and 106, or the Health Care Flexible Spending Account Program if such Health Care Flexible Spending Account Program is subject to the provisions of CHIPRA); or

N. Any such other events as may be permitted under the Regulations.

Except as otherwise required or permitted under the terms of a Benefit program as set forth in an Incorporated Document, a change in election due to a Qualified Change in Status must be made within 30 days of the date of the Qualified Change in Status and shall be effective as soon as it is administratively feasible, but in no event earlier than the first pay period beginning after a new Agreement (or such other form as may be promulgated by the Administrator for such purpose) is completed and returned to the Administrator. Changes in elections due to a Qualified Change in Status shall only be effective as to Contributions and Benefits under any Optional Benefit Program on and after the effective date of such change. However, election changes made pursuant to a special enrollment right as permitted by HIPAA may result in coverage being made available retroactively to the date of the Qualified Change in Status. Notwithstanding the foregoing, an election change made pursuant to a special enrollment right permitted by CHIPRA must be made within 60 days of the date of the qualifying event. Coverage will become effective no later than the first day of the first calendar month beginning after the date on which a new Agreement (or such other form as may be promulgated by the Administrator for such purpose) is completed and returned to the Administrator.

No Participant shall be allowed to reduce the Participant's election for the Health Care Flexible Spending Account Program or the Dependent Care Flexible Spending Account Program to a point where the annualized Contribution for such benefits is less than the amount already reimbursed. In addition, any change in an election affecting annual Contributions to any available Optional Benefit Program pursuant to this Section also will change the maximum reimbursement benefits for the remaining portion of the Period of Coverage.

If a Participant becomes entitled to an increase in his or her coverage amount under a Benefit that is paid for with after-tax dollars during a Period of Coverage as a result of an increase in his or her Compensation, the Participant may elect to increase his or her Contributions towards the cost of such coverage without experiencing a Qualified Change in Status if the new election is on account of and consistent with the increase in his or her Compensation; provided, however, that the Participant may not otherwise change his or her election with respect to such Benefit during the Period of Coverage unless he experiences a Qualified Change in Status.

Notwithstanding any provisions in this Section to the contrary, a Participant in the HSA Program may elect to increase, decrease, or revoke his election to make Contributions to his HSA on a prospective basis at any time in accordance with the procedures established by the Administrator. Any such election shall be effective as soon as administratively practicable following the date the Participant makes such an election in accordance with the procedures established by the Administrator.

Section 4.6 Forfeiture. Except as otherwise provided in Sections 5.3 or 5.4, within a reasonable period of time established by the Administrator after the last date by which claims may be submitted for each Period of Coverage, any portion of a Participant's Contributions that are attributable to such immediately previous Period of Coverage and which cannot be

distributed by the Employer for the provision of Benefits under the Optional Benefit Program for which the Contributions were made based on the Participant's election to participate during such Period of Coverage, shall be forfeited by the Participant and returned to the Employer. This forfeiture requirement shall be applied individually for each Optional Benefit Program.

Section 4.7 Automatic Termination of Election. Except as otherwise provided in the Plan, elections made or deemed to be made under this Plan will automatically terminate on the earlier of the last day of the applicable Period of Coverage or the date on which the Participant ceases to be a Participant in the Plan, although coverage under an Optional Benefit Program may continue if and to the extent provided by such Optional Benefit Program or applicable state or federal law.

Section 4.8 Cessation of Required Contributions. Nothing in this Plan shall prevent the cessation of coverage or Benefits under an Optional Benefit Program, in accordance with the terms of such program, on account of a Participant's failure to pay the Participant's share of the costs of such coverage or Benefits, through Compensation reduction or otherwise.

ARTICLE V

OPTIONAL BENEFIT PROGRAMS

Section 5.1 Participant Elections. Subject to the limitations set forth in each Optional Benefit Program for each Period of Coverage, an eligible Employee or a Participant may elect, in accordance with the election procedures described in Article IV, or be deemed to have elected, to receive his or her full Compensation in cash, or to have a portion of his or her Compensation applied as Contributions toward the purchase of Benefits under one or more of the following Optional Benefit Programs under the Plan:

- A. Premium Conversion Program;
- B. Health Care Flexible Spending Account Program;
- C. Dependent Care Flexible Spending Account Program; or
- D. The HSA Program.

In addition to the Optional Benefit Programs, the Employer may provide unilateral benefits on a non-elective basis that under the Plan will be provided to all eligible Employees without any cost to or election required by such Employees. In general, such Benefits, as well as any other Benefits that are not eligible to be offered under a Cafeteria Plan, shall not be considered offered under or through the Cafeteria Plan contained in the Plan.

Section 5.2 Premium Conversion Program.

- A. Enrollment. In accordance with the eligibility requirements of Article III of the Plan and the election procedure in Article IV of the Plan, an eligible Employee or Participant may elect to participate in one or more Optional Benefit Programs by agreeing to make (or being deemed to agree to make) the required Contributions, if any, for such Benefit(s). For each Plan Year, the Employer shall establish the amount of Contributions (if any) required to participate in any such Benefit or any component thereof under the Premium Conversion Program. If the Employer changes the amount of Contributions required to participate in any such Benefit during the Plan Year, then a Participant who has elected (or is deemed to have elected) to participate in the Premium Conversion Program shall have his or her Contributions automatically adjusted to reflect such change. If there are no Contributions required by the Employer to participate in any such Benefit or any component thereof under the Premium Conversion Program, the Employer may automatically enroll eligible Employees as Participants in such Benefit program(s).
- B. Benefit(s). While an election to receive Benefits under the Premium Conversion Program may be made under the Plan, the types and amounts of Benefits available under the Plan, the requirements for participating in any Benefit program, and the other terms and conditions of coverage and benefits under any Benefit program are as set forth, from time to time, in the Incorporated Documents which govern such Benefits. The Employer retains the right to enter into a contract with one or more insurance companies, providers, or administrators for the purpose of providing Benefits to Employees, and to change

or eliminate coverage or insurance companies, providers, or administrators at any time.

- C. Benefits Claims Procedure. If any person believes he or she is being denied any rights or benefits under any Benefit program, such person may file a claim in writing in accordance with the claims procedures of the Benefit program, which shall in all cases control.
- D. After-Tax Contributions. Employee Contributions shall generally be made on a pre-tax basis. Notwithstanding the foregoing, the Employer may, from time to time, allow or require Participants to designate that certain Contributions required by the Employer to participate in certain Benefits under the Premium Conversion Program shall be made on an after-tax basis, even though such Contributions may qualify for an exclusion from the Participant's gross income under Code Section 125. Any such after-tax Benefits, as well as Benefits that are not eligible to be provided under a Section 125 arrangement, including Benefits for a Participant's Dependent that is not the Participant's Tax Dependent shall be considered to be provided outside of the Cafeteria Plan contained in the Plan and Contributions for such Benefits will be paid for on an after-tax basis.

Section 5.3 Health Care Flexible Spending Account Program.

- A. Definitions. For purposes of the Health Care Flexible Spending Account Program, the following special definitions shall apply:
 - 1. Dependent. A dependent as defined in Code Section 105(b) for purposes of determining who is eligible to incur expenses that may be reimbursable under the Plan. Thus, a Dependent for purposes of the Health Care Flexible Spending Account Program includes a Participant's spouse under the Code and any other Dependent of the Participant who is the Participant's Tax Dependent and does not include a Participant's Dependent who is not a Tax Dependent of the Participant as defined in Code Section 105(b). However, any Dependent Eligible Child to whom Code Section 152(e) applies (regarding a child of divorced parents, etc. where one or both parents have custody of the child for more than half of the calendar year and whether the parents together provide more than half of the child's support for the calendar year) is treated as a Dependent of both parents.
 - 2. Eligible Medical Expenses. Those expenses incurred during a Period of Coverage by the Participant or the Participant's Dependents after the date of the Participant's participation in the Health Care Flexible Spending Account Program, which are allowable as deductions under Code Section 213(d) (and permitted by Code Section 125). Eligible Medical Expenses, however, do not include any expenses which are reimbursable under any other health insurance plan, whether or not sponsored by the Employer and whether insured, through a health maintenance organization, preferred provider organization or otherwise. Eligible Medical Expenses also do not include expenses incurred for the payment of premiums under any health insurance plan whether or not sponsored by the Employer. For purposes of the Health Care Flexible Spending Account Program, an

expense is incurred when the Participant, Spouse or Dependent is furnished the medical care or services giving rise to the claimed expense. In all cases, a Participant must submit evidence that the Eligible Medical Expenses were paid in order to receive reimbursement. Except as otherwise permitted under Code Section 125 and applicable Regulations, an over-the-counter drug or medicine is an Eligible Medical Expense only if the drug or medicine is prescribed (even if it is available without a prescription) or is insulin. Over-the-counter medical supplies are Eligible Medical Expenses to the extent such supplies are for medical care (within the meaning of Code Section 213(d)).

3. Health Care Expense Account. The bookkeeping account maintained by the Administrator for each Participant that reflects the amount of Contributions allocated for the purchase of benefits consisting of the pre-tax payment of Eligible Medical Expenses under the Health Care Flexible Spending Account Program, as well as the amount of Eligible Medical Expenses reimbursed from the Health Care Flexible Spending Account Program on behalf of the Participant.
 4. Highly Compensated Individual. Notwithstanding the definition of Highly Compensated Individual contained in Article II, for purposes of the nondiscrimination rules set forth in paragraph E, below, Highly Compensated Individual means an individual who is considered a Highly Compensated Individual under Code Section 105(h) and the Regulations thereunder.
 5. Period of Coverage. The calendar year (January 1 through December 31) for purposes of a Participant electing and making Contributions to his or her Health Care Expense Account. Solely for purposes of incurring Eligible Medical Expenses, Period of Coverage means the calendar year plus a "grace period" of 2½ months following the end of the calendar year. Accordingly, each Participant has 14 months and 15 days (i.e., until March 15 of the following year) to incur Eligible Medical Expenses for the Period of Coverage before forfeiting any amounts remaining in his or her Health Care Expense Account pursuant to paragraph J. Notwithstanding the foregoing, the Period of Coverage for incurring Eligible Medical Expenses is the calendar year and the 2½ month grace period does not apply for a Plan Year with respect to a Participant who elects to participate in the HSA Program for the following Plan Year.
- B. Enrollment. In accordance with the eligibility requirements of Article III of the Plan and the election procedure in Article IV of the Plan, an eligible Employee or Participant may elect to participate in the Health Care Flexible Spending Account Program. Such Employee or Participant shall designate the amount of Contributions that is to be allocated for benefits under the Health Care Flexible Spending Account Program for the Period of Coverage (or, in the case of the initial election, the remainder of the Period of Coverage). Notwithstanding the foregoing, an eligible Employee who elects to participate in the HSA Program for a Plan Year is not eligible to participate in the Health Care Flexible Spending Account Program for that Plan Year.

- C. Coverage. For any Period of Coverage, Participants covered under the Health Care Flexible Spending Account Program may submit claims for the reimbursement of Eligible Medical Expenses up to the maximum level of reimbursement elected by the Participant under the Health Care Flexible Spending Account Program pursuant to this Article V of the Plan (properly reduced as of any particular time for prior reimbursements for the same Period of Coverage). The maximum annual amount of Contributions which a Participant may allocate for benefits under the Health Care Flexible Spending Account Program for any Period of Coverage is set forth in an Incorporated Document and may be adjusted from time to time. The Administrator shall pay all permitted claims for reimbursement directly to the Participant upon presentation of satisfactory documentation regarding the Eligible Medical Expenses within a reasonable time after the expense was incurred, but in no event later than the limitation set forth in paragraph H. The Administrator may require such documentation and other information regarding the claim as it deems necessary to confirm that the expenses claimed are Eligible Medical Expenses, including written evidence from an independent third party showing the nature and amount of the expense and certification by the Participant that the expense qualifies for reimbursement. Proper claims will be paid as soon as administratively practicable. If, during the grace period from January 1 through March 15 referenced in paragraph A.5 above, a Participant incurs Eligible Medical Expenses which exceed the maximum reimbursement level for the Period of Coverage to which the grace period is applicable, then upon proper claim submission, the Administrator shall pay such claim first from the amount carried forward from the prior Period of Coverage, if any, and then from the Health Care Expense Account applicable for the current Period of Coverage, if any.
- D. Termination of Participation. During any Period of Coverage, if a Participant terminates employment with the Employer, then such Participant shall automatically cease to participate in the Health Care Flexible Spending Account Program for the remainder of such Period of Coverage, except as otherwise provided under COBRA. In the event of termination during the Period of Coverage, unless the Participant elects COBRA Continuation Coverage, the Participant shall have until the March 31 following the close of the Plan Year during which the Participant's employment with the Employer terminated (or, if March 31 falls on a Saturday, Sunday or holiday, the next following business day) to submit Eligible Medical Expenses incurred during the Period of Coverage (up to the date of termination) for reimbursement.
- E. Discrimination Prohibited. This Health Care Flexible Spending Account Program is intended to qualify as a medical expense reimbursement plan under Code Section 105 and shall be interpreted and administered in accordance with that Code Section and the Regulations thereunder. The Health Care Flexible Spending Account Program shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate and the benefits provided shall not discriminate in favor of Highly Compensated Individuals who are Participants, in accordance with Code Section 105.
- F. Correcting Discrimination. If the Administrator determines that any of the nondiscrimination requirements applicable to the Health Care Flexible Spending Account Program will not be satisfied, the Administrator may, in its discretion,

reject any Employee or Participant elections or reduce any Employee Contributions in order to ensure compliance with these requirements. Any such action shall be carried out in a uniform and nondiscriminatory fashion and may include a reduction in the Contributions of one or more Highly Compensated Individuals.

- G. Recovery of Excess Reimbursements. Notwithstanding any other provision in the Plan or the Health Care Flexible Spending Account Program, the Employer (or the Administrator acting on the Employer's behalf and with the Employer's consent), may pursue such remedies as are available under applicable state and federal law to recover any amounts paid to or on behalf of a Participant who has terminated participation in the Health Care Flexible Spending Account Program which exceed the total amount of Contributions actually applied toward the purchase of benefits under the Health Care Flexible Spending Account Program, but only to the extent permitted under the Code.
- H. Date By Which Claims Must Be Submitted. Unless otherwise provided under an Incorporated Document, in order to receive reimbursement for Eligible Medical Expenses incurred during any Period of Coverage in which the Participant has elected to participate in the Health Care Flexible Spending Account Program, claims for reimbursement of such Eligible Medical Expenses must be properly submitted to the Administrator on or before the March 31st following the close of such Period of Coverage (or, if March 31st falls on a Saturday, Sunday or holiday, the next following business day).
- I. Qualified Change Of Status. Notwithstanding Section 4.5 of the Plan, a Participant who has elected to participate in the Health Care Flexible Spending Account Program for a Period of Coverage shall be permitted to change an election under the Health Care Flexible Spending Account Program due to a Qualified Change of Status (as defined in Section 4.5 of the Plan) only for those reasons as listed in Sections 4.5.A., B., C., D., G., I. and K. and for the reason listed in Section 4.5.E. if the reason for the Qualified Change of Status impacts the Dependent's eligibility under the Health Care Flexible Spending Account Program and for the reasons listed in Section 4.5.L. and M. if the Health Care Flexible Spending Account Program is subject to HIPAA.
- J. Forfeiture of Unused Amounts. Any amount remaining in a Participant's Health Care Expense Account at the end of any Period of Coverage (which includes the "grace period" referenced in paragraph A.5, above) and after the date by which claims must be submitted shall be forfeited and returned to the Employer.
- K. Use Of Debit/Credit Cards. The Employer may permit the use of debit and/or credit cards for the reimbursement of Eligible Medical Expenses under the Health Care Flexible Spending Account Program. All reimbursements of Eligible Medical Expenses using such debit and/or credit cards must comply with the substantiation requirements of Code Section 125 and associated Regulations, Revenue Ruling 2003-43, Notices 2006-69 and 2007-2, the 2007 proposed regulations under Code Section 125, and any subsequent relevant guidance of general application including, but not limited to, the following provisions:

1. **Reimbursement Card Provisions.**
 - a. **Uninsured Eligible Medical Expenses are reimbursable up to a maximum reimbursement amount, determined at the beginning of each Period of Coverage.**
 - b. **The Participant's use of the card is limited to the maximum dollar amount of coverage available in the Participant's Health Care Expense Account.**
 - c. **Card use is limited to:**
 - (i) **Physicians, dentists, vision care offices, hospitals, and other medical care providers (as identified by merchant category code ("MCC"));**
 - (ii) **"Qualifying pharmacies" - stores with the "drug stores and pharmacies" MCC that, on a location-by-location basis, meet the 90% gross receipts test (i.e., 90% of the store's gross receipts during the prior taxable year, determined on a store location by store location basis, consisted of items that qualify as Code Section 213(d) medical expenses); and**
 - (iii) **Stores that have implemented the IAS.**
 - d. **The card will be cancelled automatically when the Participant ceases to participate in the Health Care Flexible Spending Account Program.**
2. **Electronic Reimbursement Of Eligible Medical Expenses.**
 - a. **Upon enrollment in the Health Care Flexible Spending Account Program, a Participant shall receive a reimbursement card. The Participant may elect whether to activate the reimbursement card and whether to order additional cards.**
 - b. **Prior to receipt of the card and with respect to each Period of Coverage thereafter, the Participant agrees in writing that: (i) the card will be used only for Eligible Medical Expenses of the Participant and the Participant's Dependents; (ii) any Eligible Medical Expense paid with the card has not been reimbursed and the Participant will not seek reimbursement under any other plan covering health benefits; and (iii) the Participant will acquire and retain sufficient documentation (including receipts and invoices) for any Eligible Medical Expense paid with the card.**
 - c. **The card shall include a statement providing that the agreements in b., above, are reaffirmed each time the card is used.**

- d. When the card is used at point-of-sale, the merchant/service provider is paid in full and the card balance is reduced by the same amount.
3. Other Reimbursement Of Eligible Medical Expenses. A Participant may receive benefits under the Health Care Flexible Spending Account Program without using the card by using one of the following methods:
 - a. Submitting an explanation of benefits (“EOB”) from the health insurance provider or administrator, or a receipt from a merchant or service provider. The Health Care Flexible Spending Account Program will either issue payment to the merchant or service provider directly, or if the Participant has paid the health expense, the Health Care Flexible Spending Account Program will reimburse the Participant for the Eligible Medical Expense.
 - b. Entering the EOB information from a health insurance provider or administrator, or information from a merchant’s or service provider’s receipt online. The Health Care Flexible Spending Account Program will issue payment to the merchant or service provider directly for the Eligible Medical Expense.
 4. Substantiation Of Claims. Every claim paid under the Health Care Flexible Spending Account Program must be reviewed and substantiated to ensure that it qualifies for payment or reimbursement, including claims paid with an electronic payment card.
 - a. Co-Payments. If the dollar amount of the transaction at a “health care provider” (i.e., physician, dentist, vision care office, hospital, or other medical care providers, identified by MCC) or qualifying pharmacy equals an exact multiple of not more than five times the dollar amount of the co-payment imposed for that service (or exact matches of multiples or combinations of co-payments for the specific service that do not exceed five times the maximum co-payment for the service) under the Participant’s health program, the charge is automatically fully substantiated and the Participant does not need to submit a receipt or further documentation.
 - b. Recurring Expenses. A recurring claim at a health care provider or qualifying pharmacy that is the same as a previously approved claim with respect to the amount, health care provider or qualifying pharmacy and time period (e.g., a prescription drug refill and recurring therapy) is automatically substantiated and the Participant does not need to submit a receipt or further documentation.
 - c. Automatic Substantiation. If an electronic payment at a health care provider or qualifying pharmacy is accompanied at the time and point of sale with verifying information from a third-party that the claim is an Eligible Medical Expense and the information is sent electronically (e.g. by Internet, intranet, E-mail, or telephone)

or by paper, the charge is automatically substantiated and no further substantiation or documentation is required. The third-party that provides the verifying information must be independent of the Participant and the Participant's Dependents. However, the information may be in the form of a note from an administrator (e.g., pharmacy benefits manager) or in the formal treatment codes entered by the provider.

- d. Inventory Information Approval System. Expenses are automatically substantiated if they are incurred at merchants that use the IIAS (i.e., a system that uses inventory control information to compare the items purchased against a list of items that qualify as Eligible Medical Expenses) to ensure that cards are used only for Eligible Medical Expenses, regardless of the merchant's MCC (so long as the Employer can produce auditable records of all transactions with such a system).

Card transactions at health care providers or qualifying pharmacies that are not auto-adjudicated under a. through e., above, but that are paid at the time of the card swipe are conditional pending confirmation that they were for Eligible Medical Expenses. If the status of an expense as an Eligible Medical Expense is not substantiated using one of the methods listed in a. through e., above, the expense must be substantiated by the Participant submitting information, documentation or receipts showing: (i) a description of the service or product; (ii) the date the service or product was provided; and (iii) the amount charged for the service or product.

If a Participant is required to substantiate an expense but fails to do so within the time period set forth in the Administrator's policies and procedures, as may be modified from time-to-time, the Participant's use of his card will be suspended until such substantiation is provided.

- 5. Over-the-Counter Drugs. Except as provided in this Section, electronic payment cards may not be used to purchase over-the-counter drugs at any providers or merchants after January 15, 2011.
 - a. An electronic payment card may be used to purchase over-the-counter drugs at drug stores and pharmacies, non-health care merchants that have pharmacies, and mail-order or web-based vendors that sell prescription drugs if the following requirements are met:
 - (i) Before the purchase, a prescription is presented (in any format) to the pharmacist, the over-the-counter drug is dispensed by the pharmacist in accordance with applicable legal requirements, and an Rx number is assigned;
 - (ii) The pharmacy or other vendor retains a record of the Rx number, the name of the purchaser or patient, and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements for card programs;

- (iii) The records are available to the Administrator, Employer or its agent upon request (e.g., in the event of an IRS audit);
- (iv) The card system will not accept a charge for an over-the-counter drug unless an Rx number has been assigned; and
- (v) The requirements of any other IRS guidance regarding electronic card programs are satisfied.

If requirements above are satisfied, the transaction is considered to be fully substantiated at the time and point of sale. In addition, an electronic payment card can be used to purchase prescribed over-the-counter drugs at a qualifying pharmacy if the above requirements are satisfied or proper substantiation is submitted.

- b. Electronic payment cards may be used to purchase over-the-counter drugs from other vendors with health care-related MCCs (e.g., physicians or hospitals) if the following requirements are met:
 - (i) The vendor retains a record of the name of the purchaser or patient and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements for electronic card programs;
 - (ii) The records are available to the Administrator, Employer or its agent upon request; and
 - (iii) The requirements of any other IRS guidance regarding electronic card programs are satisfied.

Transactions meeting these requirements are considered to be fully substantiated at the time and point of sale.

6. Improper Payments. In the event that a claim is reimbursed or paid and the expense is not payable under the Health Care Flexible Spending Account Program, the Administrator shall apply the following correction procedures:

- a. First, the card must be de-activated until the amount of the improper payment is recovered.
- b. Next, the Administrator must demand that the Participant repay the improper payment. The Administrator should send a letter to the Participant identifying the amount of the improper payment, the reason for requiring repayment, and the timeframe in which the repayment must be made. The notice will constitute an adverse benefit determination under Section 6.13.

- c. If the demand for repayment is unsuccessful, then the Administrator is authorized to withhold an amount equal to the improper payment from the Participant's Compensation, to the full extent permitted under applicable law.
 - d. If the improper payment is still outstanding and amounts are not available to be withheld, the Administrator shall apply a substitution or offset approach against subsequent valid claims incurred during the same Period of Coverage.
 - e. If the correction methods set forth above are not successful, the Participant remains indebted to the Employer for the amount of the improper payment and, consistent with its business practices, the Employer may treat the payment as any other business indebtedness and take the same steps it would take to collect an equivalent business debt, including, to the extent applicable, garnishment or filing litigation.
 - f. If repayment has not been made after all of the steps set forth above have been taken, the improper payment shall be written off by the Employer and the improper payment shall be reported as income to the Participant or former Participant.
7. Use of an Electronic Card is not a Claim. Absent guidance issued after the Effective Date to the contrary, the Administrator does not consider use of an electronic card to pay for services a claim for benefits under Section 6.13 of the Plan. A claim under the Health Care Flexible Spending Account Program is not filed for purposes of the claims procedures set forth in Section 6.13 of the Plan until the Participant submits a written request for reimbursement to the Administrator.
- L. Qualified Reservist Distributions. Except as otherwise provided in the applicable Incorporated Documents, a Participant who is a Qualified Reservist may elect to receive a distribution of all or a portion of his or her unused Health Care Expense Account to the extent that such distribution is a Qualified Reservist Distribution. For purposes of this Section 5.3.L., a "Qualified Reservist" is a Participant who is, by reason of being a member of a reserve component, as defined in Section 101 of Title 37 of the United States Code, ordered or called to active duty for a period in excess of 179 days or for an indefinite period. A "Qualified Reservist Distribution" is a distribution that is made during the period beginning on the date the Qualified Reservist is ordered or called to active duty and ending on the last day that reimbursements for Eligible Medical Expenses could otherwise be made pursuant to Section 5.3.H. for the Plan Year which includes the date the Qualified Reservist is ordered or called to active duty. The portion of the Health Care Expense Account available for a Qualified Reservist Distribution shall be limited to the amount contributed to the Health Care Expense Account as of the date of the Qualified Reservist Distribution request minus the Health Care Expense Account reimbursements received as of the date of the Qualified Reservist Distribution request. A Participant who receives a Qualified Reservist Distribution is not entitled to any additional benefits under the Health Care

Flexible Spending Account Program for the Plan Year in which he receives the Qualified Reservist Distribution.

- M. Transfer of Accounts in Corporate Transaction. In the event of a corporate transaction in which the Employer employs employees of the seller, and subject to the terms of the health care flexible spending accounts plans of the seller and to the terms agreed to between the parties in the applicable transaction documents, such “transferred” employees who elected to participate in a health care flexible spending account program of the seller may continue to exclude salary reduction amounts and health care reimbursements from gross income without interruption at the same level of coverage after becoming Employees of the Employer upon transfer to this Plan of any net accumulated balances under the health care flexible spending accounts of the “transferred” employees under the seller’s plan as of the closing of the transaction. Such transferred Employees shall become Participants in the Health Care Flexible Spending Account Program in this Plan as of the beginning of the seller’s plan year and at the level of coverage provided under the seller’s health care flexible spending account plan provided such plan operated on a calendar plan fiscal year. Notwithstanding the foregoing, any participant in the seller’s health care flexible spending account program who elects to continue participation in the seller’s program (e.g., by electing COBRA Continuation Coverage), shall not be covered by the Health Care Flexible Spending Account Program in this Plan for the remainder of the Plan Year. Further, the Health Care Flexible Spending Account Program in this Plan shall provide reimbursement for Eligible Medical Expenses incurred by the transferred Employees at any time during the Period of Coverage (including claims incurred before the corporate transaction), up to the amount of the Employees’ elections and reduced by amounts previously reimbursed by the seller.

In the event of a corporate transaction in which the Employer divests employees to an unrelated buyer, and as may be agreed to between the parties in the applicable transaction documents, the Plan may permit the transfer of any Health Care Flexible Spending Account balance as of the date of the divestiture transaction to a health care flexible spending account program of the buyer for such impacted “transferred” employees. As of the date of such Health Care Flexible Spending Account transfer, the Plan shall not be responsible for providing reimbursement for any Eligible Medical Expenses, regardless of when such expense was incurred during the Plan Year.

If the other party to a corporate transaction operates its health care flexible spending account program on a plan fiscal year other than the calendar year, such transfer of accounts, if agreed to occur, shall be prorated to apply to the balance of the calendar year only, if the other party’s plan fiscal year would extend beyond that date, based on a ratable allocation of the contribution amounts elected for the full plan year over such truncated period. If the other party’s plan fiscal year would end before the end of the calendar year in which the transfer occurs, then the affected “transferred” employees shall make a new election as a new employee for the balance of the calendar year (in the case of a transfer to this Plan) or shall have their transferred amounts ratably prorated to the end of the other party’s fiscal year (in the case of a transfer from this Plan to

a plan with a fiscal year ending before the end of the current Plan Year in which the transfer occurs).

Section 5.4 **Dependent Care Flexible Spending Account Program.**

A. **Definitions.** For purposes of the Dependent Care Flexible Spending Account Program, the following special definitions shall apply:

1. **Dependent.**

- a. A dependent (as defined in Code Section 152(a)(1)) of a Participant who is under the age of 13;
- b. A dependent (as defined in Code Section 152(a), but determined without regard to the income test for being a qualifying relative) of a Participant, who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than one-half of the taxable year; or
- c. The Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than one-half of the taxable year.

2. **Dependent Care Account.** The bookkeeping account maintained by the Administrator for each Participant which reflects the amount of Contributions which have been allocated for the purchase of benefits under the Dependent Care Flexible Spending Account Program, as well as the amount of Eligible Dependent Care Expenses reimbursed from the Dependent Care Flexible Spending Account Program on behalf of the Participant.

3. **Eligible Dependent Care Expenses.** Those expenses paid or incurred after the date of the Participant's participation in the Dependent Care Flexible Spending Account Program incident to maintaining employment which would be considered employment related expenses under Code Section 21(b)(2) (relating to expenses for household and dependent care services necessary for gainful employment) if paid for by the Participant, excluding amounts paid to an individual who is a dependent for tax purposes of the Participant (or his or her spouse), or to a child of the Participant who has not attained age 19 at the close of the taxable year. An expense for services provided outside of the Employee's household to care for a Dependent is an Eligible Dependent Care Expense only if the expense is for the care of (i) a Dependent described in Section 5.4.A.1.a.; or (ii) a Dependent described in Section 5.4.A.1.b. or c. who regularly spends at least eight hours each day in the Employee's household.

4. **Earned Income.** Earned income, as defined in Code Section 32(c)(2), excluding any amounts paid or incurred by the Employer for dependent care assistance (as defined by Code Section 129(e)(1)) to a Participant.

5. Highly Compensated Individual. Notwithstanding the definitions of Highly Compensated Individual contained in Article II, for purposes of the nondiscrimination rules set forth in paragraph G., below, Highly Compensated Individual means an Employee who is (as determined under Code Section 129) a highly compensated employee within the meaning of Code Section 414(q).
- B. Enrollment. In accordance with the eligibility requirements of Article III of the Plan and the election procedure in Article IV of the Plan, an eligible Employee or Participant may elect to participate in the Dependent Care Flexible Spending Account Program. Such Employee or Participant shall designate the amount of Contributions that are to be allocated for Benefits under the Dependent Care Flexible Spending Account Program for the Plan Year (or, in the case of the initial election, the remainder of the Plan Year).
- C. Coverage. For any Plan Year, Participants covered by the Dependent Care Flexible Spending Account Program may submit claims for the reimbursement of Eligible Dependent Care Expenses from Contributions previously allocated to the Participant's Dependent Care Account. The maximum annual amount of Contributions which may be allocated by the Participant for Benefits under the Dependent Care Flexible Spending Account Program is \$5,000, or \$2,500 if the Participant is married (as defined in Code Section 21(e)(3) and (4)) but files a separate income tax return, in accordance with Code Section 129. If these Code Section 129 limitations are changed in the future, the limitations applicable to the Dependent Care Flexible Spending Account Program hereunder shall automatically be changed to correspond thereto.
- D. Covered Expenses. Each Participant shall be entitled to reimbursement from his or her Dependent Care Account for documented Eligible Dependent Care Expenses incurred during the Plan Year for which the Participant participates in the Dependent Care Flexible Spending Account Program. Such reimbursements shall only be made from Contributions previously allocated to the Participant's Dependent Care Account during the Plan Year (properly reduced as of any particular time for prior reimbursements for the same Plan Year). An Eligible Dependent Care Expense shall be considered incurred when the service is provided, and not when the Participant is formally billed, charged or pays for the Eligible Dependent Care Expense. In all cases, in order to receive reimbursement, the Participant must submit claims for Eligible Dependent Care Expenses to the Administrator on or before the March 31st following the last day of the Plan Year in which such expenses were incurred (or, if March 31st falls on a Saturday, Sunday or holiday, the next following business day). The Administrator shall pay all permitted claims directly to the Participant upon presentation of satisfactory documentation regarding the Eligible Dependent Care Expenses within a reasonable time after the expense was incurred, but in no event later than the limitation set forth above. The Administrator may require such documentation and other information regarding the claim as it deems necessary to confirm that the expenses claimed are Eligible Dependent Care Expenses, including written evidence from an independent third party showing the nature and amount of the expense and certification by the Participant that the expense qualifies for reimbursement. Proper claims will be paid as soon as administratively practicable.

E. Reimbursement Limitations. No payment otherwise due under the Dependent Care Flexible Spending Account Program shall exceed the lesser of:

1. The Earned Income of such Participant for such year;
2. The Earned Income of the Spouse (if any) of such Participant for such year; or
3. the credit balance in the Participant's Dependent Care Account as of the date such payment is to be made.

For purposes of paragraphs 1 and 2, if the Participant's spouse is a full-time student at an educational institution or physically or mentally incapable of caring for himself or herself, such spouse shall be deemed to be gainfully employed and to have Earned Income of \$250 per month if the Participant has only one Dependent, and \$500 per month if the Participant has two or more Dependents, as provided under Code Section 21(d)(2). In the case of any husband and wife, the preceding sentence shall apply with respect to only one spouse for any one month. If these limitations are changed in the future under the Code, then the Dependent Care Flexible Spending Account Program shall be deemed to incorporate the new limitations as of their effective date.

F. Termination of Participation. If a Participant terminates employment with the Employer, then such Participant shall automatically cease to participate in the Dependent Care Flexible Spending Account Program for the remainder of such Plan Year. A Participant in the Dependent Care Flexible Spending Account Program may continue to submit claims for reimbursement of Eligible Dependent Care Expenses incurred through December 31 of the Plan Year during which the Participant's employment with the Employer terminated and may request reimbursement for such Eligible Dependent Care Expenses through the March 31st following the close of the Plan Year during which the Participant's employment with the Employer terminated (or, if March 31st falls on a Saturday, Sunday or holiday, the next following business day), even though the Participant terminated employment with the Employer during the Plan Year. Such expenses must qualify as Eligible Dependent Care Expenses in order to be reimbursed from the Participant's Dependent Care Account.

G. Discrimination Prohibited. This Dependent Care Flexible Spending Account Program is intended to qualify as an assistance program under Code Section 129 and shall be interpreted and administered in accordance with that Code Section and the Regulations thereunder.

1. Eligibility. The Dependent Care Flexible Spending Account Program shall not discriminate in favor of Employees who are Highly Compensated Individuals or their Dependents with respect to eligibility to participate, in accordance with Code Section 129.

2. Contributions/Benefits. The Dependent Care Flexible Spending Account Program shall not discriminate in favor of Employees who are Highly Compensated Individuals as to benefits or Contributions, in accordance with Code Section 129.
3. Principal Shareholder Limitation. Not more than twenty-five percent (25%) of the amounts paid or incurred by the Employer for assistance (as defined by Code Section 129(e)(1)), including Eligible Dependent Care Expenses reimbursed under the Dependent Care Flexible Spending Account Program during a Plan Year, may be provided for the class of persons (or their Spouses or Dependents), each of whom (on any day of such Plan Year) owns more than five percent (5%) of the stock or the capital or profits interest in the Employer, as determined under Code Section 129.
4. Average Benefit Limitation. The average benefits provided to all Employees who are not Highly Compensated Individuals under the Dependent Care Flexible Spending Account Program (and all other assistance programs of the Employer) must be at least fifty-five percent (55%) of the average benefits provided to all Highly Compensated Individuals under the Dependent Care Flexible Spending Account Program (and all other assistance programs of the Employer). For purposes of this paragraph 4., in the case of Employees whose benefits are provided by salary reduction agreements, such as an Agreement, any Employees whose compensation (as defined by Code Section 414(q)(7)) is less than \$25,000 may be disregarded.
5. Excluded Employees. For purposes of paragraphs 1. and 4., the following Employees may be excluded:
 - a. Employees who have not completed one year of service with the Employer and have not attained age 21; and
 - b. Employees not included in an assistance program of the Employer (including the Dependent Care Flexible Spending Account Program) who are covered by a collective bargaining agreement, if there is evidence that benefits were the subject of good faith bargaining between the Employer and the representative of such Employees.
6. Correcting Discrimination. If the Administrator determines that any of the nondiscrimination requirements above will not be satisfied, the Administrator may, in its discretion, reject any Employee or Participant elections, impose dollar caps or other limitations on the Contributions of Highly Compensated Individuals, or reduce any Employee Contributions in order to ensure compliance with these requirements. Any such action shall be carried out in a uniform and nondiscriminatory fashion and may include a reduction in the Contributions of one or more Highly Compensated Individual(s).

- H. Annual Report to Participants. The Administrator shall furnish to each Participant on whose behalf benefits are paid, an electronic and/or written statement in a manner permitted by federal law, showing the amounts reimbursed or expenses incurred during the previous calendar year. In addition, a Participant may access information regarding his or her Dependent Care Account electronically.
- I. Forfeiture of Unused Amounts. Any amount remaining in a Participant's Dependent Care Account at the end of any Plan Year and after the date by which claims must be submitted shall be forfeited and returned to the Employer.
- J. Transfer of Accounts in Corporate Transaction. In the event of a corporate transaction in which the Employer employs employees of the seller, and subject to the terms of the dependent care flexible spending account plans of the seller and to the terms agreed to between the parties in the applicable transaction documents, such "transferred" employees who elected to participate in a dependent care flexible spending account program of the seller may continue to exclude salary reduction amounts and dependent care reimbursements from gross income without interruption at the same level of coverage after becoming Employees of the Employer upon transfer to this Plan of any net accumulated balances under the dependent care expense accounts of the "transferred" employees under the seller's plan as of the closing of the transaction. Such transferred Employees shall become Participants in the Dependent Care Flexible Spending Account Program in this Plan as of the beginning of the seller's plan year and at the level of coverage provided under the seller's reimbursement account plan provided such plan operated on a calendar plan fiscal year. Further, the Dependent Care Flexible Spending Account Program in this Plan shall provide reimbursement for Eligible Dependent Care Expenses incurred by the transferred Employees at any time during the Plan Year (including claims incurred before the corporate transaction), up to the amount of the Employees' election and reduced by amounts previously reimbursed by the seller.

In the event of a corporate transaction in which the Employer divests employees to an unrelated buyer, and as may be agreed to between the parties in the applicable transaction documents, the Plan may permit the transfer of any Dependent Care Flexible Spending Account balance as of the date of the divestiture transaction to a dependent care flexible spending account program of the buyer for such impacted "transferred" employees. As of the date of such Dependent Care Flexible Spending Account transfer, the Plan shall not be responsible for providing reimbursement for any Eligible Dependent Care Expenses, regardless of when such expense was incurred during the Plan Year.

If the other party to a corporate transaction operates its dependent care flexible spending account program on a plan fiscal year other than the calendar year, such transfer of accounts, if agreed to occur, shall be prorated to apply to the balance of the calendar year only, if the other party's plan fiscal year would extend beyond that date, based on a ratable allocation of the contribution amounts elected for the full plan year over such truncated period. If the other party's plan fiscal year would end before the end of the calendar year in which the transfer occurs, then the affected "transferred" employees shall make a new election as a new employee for the balance of the calendar year (in the case of a transfer to this Plan) or shall have their transferred amounts ratably prorated to

the end of the other party's fiscal year (in the case of a transfer from this Plan to a plan with a fiscal year ending before the end of the current Plan Year in which the transfer occurs).

Section 5.5 Health Reimbursement Account Program.

- A. Background. The HRA Program is intended to qualify as an employer-provided medical reimbursement plan under Code Sections 105 and 106 and the Regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and will be interpreted accordingly. The HRA Program is coordinated with other medical benefit program options and is not a stand-alone Benefit. The Eligible Medical Expenses reimbursed under the HRA Program are intended to be eligible for exclusion from a Participant's gross income under Code Section 105(b). The HRA Program will not be considered offered under or through the Cafeteria Plan contained in the Plan.
- B. Definitions. For purposes of the HRA Program, the following special definitions will apply:
1. Dependent. A dependent as defined in Code Section 105(b) for purposes of determining who is eligible to incur expenses that may be reimbursable under the HRA Program. Thus, a Dependent for purposes of the HRA Program does not include a Participant's Dependent who is not a Tax Dependent except to the extent such individual is a tax dependent of the Participant as defined in Code Section 105(b). However, any Tax Dependent child to whom Code Section 152(e) applies (regarding a child of divorced parents, etc. where one or both parents have custody of the child for more than half of the calendar year and whether the parents together provide more than half of the child's support for the calendar year) is treated as a Dependent of both parents. Notwithstanding the foregoing, except as otherwise provided in the applicable Incorporated Documents, a Participant's Dependents covered under an HRA Medical Program who are not the Participant's Tax Dependents are treated as the Participant's Dependents for purposes of determining the Employer Contribution to which the Participant is eligible under the HRA Program (i.e., for purposes of determining the level of coverage under the HRA Medical Program Benefit elected by the Participant for the Plan Year), if applicable.
 2. Eligible Medical Expenses. Subject to any limitations set forth in the applicable Incorporated Document(s), those expenses incurred during a Period of Coverage by the Participant or the Participant's Dependents after the date of the Participant's participation in the HRA Program which are allowable for "medical care" as defined under Code Section 213(d). An over-the-counter drug or medicine is an Eligible Medical Expense only if the drug or medicine is prescribed (even if it is available without a prescription) or is insulin. Over-the-counter medical supplies are Eligible Medical Expenses to the extent such supplies are for medical care (within the meaning of Code Section 213(d)).

Eligible Medical Expenses do not include:

- a. Any expenses which are reimbursable under any other health insurance plan or program, whether or not sponsored by the Employer and whether insured, through a health maintenance organization, preferred provider organization or otherwise, including the Health Care Flexible Spending Account Program;
- b. Health insurance premiums for individual policies or for any group health plan not sponsored or adopted by the Employer; and
- c. Medications/drugs prohibited from interstate shipment (which includes importation) to the United States because they have not been approved by the United States Federal Food, Drug and Cosmetic Act.

Notwithstanding the above, an Eligible Medical Expense for purposes of a Limited-Purpose HRA is limited to those expenses that satisfy the requirements of Revenue Ruling 2004-45 and Code Section 223 such that the expenses do not disqualify a Participant from participating in the HSA Program.

For purposes of the HRA Program, an expense is incurred when the Participant or Dependent is furnished the medical care or services giving rise to the claimed expense. In all cases, a Participant must submit evidence that the Eligible Medical Expenses were paid in order to receive reimbursement.

3. Health Reimbursement Account or HRA. A bookkeeping account established and maintained by the Administrator, or its designee, for each Participant that reflects the amount of Employer Contributions credited to the account less the amount of Eligible Medical Expenses reimbursed from the account on behalf of the Participant or his or her eligible Dependents.
4. Highly Compensated Individual. Notwithstanding the definition of Highly Compensated Individual contained in Article II of the Plan, for purposes of the nondiscrimination rules set forth in Section 5.5.I. of the Plan, Highly Compensated Individual means an individual who is considered a Highly Compensated Individual under Code Section 105(h) and the Regulations thereunder.
5. Limited-Purpose Health Reimbursement Account or Limited-Purpose HRA. A bookkeeping account established and maintained by the Administrator, or its designee, for each Limited-Purpose HRA-Eligible Participant. Such account will be credited with the balance in the Limited-Purpose HRA Participant's HRA as of last day of a Plan Year, less the amount of Eligible Medical Expenses incurred on or before the last day of the Plan Year and submitted for reimbursement by the March 31 following

the last day of the Plan Year (or, if March 31 falls on a Saturday, Sunday or holiday, the next following business day), effective as of the first day of the next Plan Year.

6. Limited-Purpose HRA-Eligible Participant. A Limited-Purpose HRA-Eligible Participant is a Participant who has an HRA balance as of the last day of a Plan Year due to participation in the PCA PPO HRA Medical Program and who becomes covered under an HSA Medical Program effective as of the first day of the next Plan Year.

C. Enrollment. When an eligible Employee enrolls in one of the HRA Medical Programs under the Plan in accordance with Article IV of the Plan, if the HRA Program is offered by the Employee's Employer, the eligible Employee will automatically be enrolled in the HRA Program and an HRA will be established for such Participant to receive benefits in the form of reimbursements for Eligible Medical Expenses. Participation under the HRA Program will begin at the same time as the eligible Employee's participation in the HRA Medical Program Benefit under the Plan. Notwithstanding the above, a Limited-Purpose HRA-Eligible Participant will automatically be enrolled in a Limited-Purpose HRA under the HRA Program effective as of the date a Limited-Purpose HRA is established for the Participant pursuant to this Section 5.5.

D. Employer and Participant Contributions.

1. Employer Contributions. As soon as administratively practicable following the beginning of each Plan Year, the Administrator will credit an amount to the HRA of each Employee who is a Participant in the HRA Program on the first day of the Plan Year in an amount set forth in, and in accordance with, the applicable Incorporated Document(s). During the Plan Year, the Administrator may credit an additional amount to the HRA of an Employee who was a Participant in the HRA Program on the first day of the Plan Year in an amount, if any, set forth in, and in accordance with, the applicable Incorporated Document(s). If an eligible Employee becomes a Participant in the HRA Program after the first day of a Plan Year, the amount, if any, that will be credited to the Participant's HRA for the Plan Year will be the amount set forth in, and in accordance with, the applicable Incorporated Document(s) and may be prorated. Further, if a Participant changes his or her coverage category under an HRA Medical Program during a Plan Year pursuant to Section 4.5 of the Plan or the provisions of the applicable Incorporated Document(s), the amount, if any, that will be credited to the Participant's HRA for the Plan Year will be the amount set forth in, and in accordance with the applicable Incorporated Document(s) and may be prorated. Except as set forth in Section 5.5.B.5., no amount shall be credited to a Limited-Purpose HRA-Eligible Participant's Limited-Purpose HRA.

Any amounts credited to a Participant's HRA are referred to as "Employer Contributions." The amount of Employer Contributions may be modified from time to time in the sole discretion of the Administrator.

2. Participant Contributions. A Participant may not make Contributions to his HRA under the HRA Program except to the extent permitted by COBRA.
 3. No Funding Under Cafeteria Plan. Under no circumstances will Contributions be made to the HRA Program under the Cafeteria Plan contained in the Plan.
- E. Benefits. A Participant is entitled to a benefit under the HRA Program for all Eligible Medical Expenses incurred by the Participant and his or her Dependents on or after the effective date of his or her participation in the HRA Program, up to the balance in the Participant's HRA (properly reduced as of any particular time for prior reimbursements to the Participant from his or her HRA). Upon receipt of a properly documented claim, the Administrator, or its designee, will pay from a Participant's HRA or reimburse a Participant from his or her HRA for any Eligible Medical Expenses up to balance in the Participant's HRA (properly reduced as of any particular time for prior reimbursements to the Participant from his or her HRA) as soon as administratively practicable. The Administrator may require such documentation and other information regarding the claim as it deems necessary to confirm that the expenses claimed are Eligible Medical Expenses, including written evidence from an independent third party showing the nature and amount of the expense and certification by the Participant that the expense qualifies for payment or reimbursement. The claims procedures set forth in the Plan will apply to a Participant's request for reimbursement from his or her HRA.
- F. Carryover of HRAs. If any balance remains in a Participant's HRA at the end of any Plan Year after all payments and reimbursements have been made for the Plan Year, the balance may be carried over to pay or reimburse Eligible Medical Expenses incurred by the Participant and his or her eligible Dependents in a subsequent Plan Year to the extent provided by, and in accordance with, the applicable Incorporated Document(s). Notwithstanding the foregoing, a Limited-Purpose HRA-Eligible Participant's Limited-Purpose HRA may be used to pay or reimburse Eligible Medical Expenses incurred by the Limited-Purpose HRA-Eligible Participant or such Participant's Dependents only during the two year Period of Coverage beginning on the first day of the Plan Year in which the Limited-Purpose HRA is effective and ending on the last day of the next following Plan Year (e.g., beginning on January 1, 2014 and ending on December 31, 2015). Any balance remaining in a Limited-Purpose HRA-Eligible Participant's Limited-Purpose HRA as of the last day of such two year Period of Coverage, after all payments and reimbursements have been made for Eligible Medical Expenses incurred during the two year Period of Coverage applicable to the Limited-Purpose HRA and timely submitted, will be forfeited.
- G. Coordination of Benefits. Benefits under the HRA Program are intended to pay or reimburse Eligible Medical Expenses not previously reimbursed or reimbursable by another health plan or program. To the extent that an otherwise Eligible Medical Expense is payable or reimbursable from another source, that other source will pay or reimburse prior to payment or reimbursement under the HRA Program. Without limiting the foregoing, if the Participant's or Dependent's Eligible Medical Expenses are covered by both the HRA Program and Health Care Flexible Spending Account Program, reimbursement of such Eligible

Medical Expenses will be made first from the Participant's HRA (or a Limited-Purpose HRA, if applicable) until all amounts available for reimbursement under the HRA Program have been exhausted. In addition, if a Participant's or Dependent's Eligible Medical Expenses are eligible for reimbursement from both an HRA and a Limited-Purpose HRA, the reimbursement of such Eligible Medical Expenses will be made first from the Limited-Purpose HRA until the Limited-Purpose HRA has been exhausted.

- H. Termination of Participation. A Participant will cease to be a Participant in the HRA Program upon the earlier of: (1) termination of the HRA Program; or (2) the date on which the Participant ceases to be an eligible Employee, provided that eligibility may continue beyond such date for purposes of COBRA Continuation Coverage. COBRA Continuation Coverage under the HRA Program includes the ability to receive reimbursement from an HRA based on the unused balance in the Participant's HRA on the date of the COBRA Qualifying Event, plus the Qualified Beneficiary may make contributions to an HRA for the COBRA coverage period on the same basis that the Employer makes contributions to the HRAs of Participants. However, in order to be entitled to COBRA Continuation Coverage under the HRA Program, the Qualified Beneficiary must elect COBRA Continuation Coverage under an HRA Medical Program offered through the Plan. In addition, a former Participant may continue to receive reimbursements from his or her HRA (other than a Limited-Purpose HRA) for Eligible Medical Expenses incurred after he or she ceases to be a Participant, until the earlier of the date the former Participant's HRA balance is exhausted, the date of the former Participant's death or the date set forth in the applicable Incorporated Document(s). A former Participant may continue to receive reimbursements from his or her Limited-Purpose HRA, if any, for Eligible Medical Expenses incurred after he or she ceases to be a Participant, until the earlier of the last day of the two year Period of Coverage described in Section 5.5.F., the date the former Participant's HRA balance is exhausted, the date of the former Participant's death or the date set forth in the applicable Incorporated Document(s). After a Participant's or former Participant's death, the Participant's or former Participant's HRA balance may be used to reimburse the Eligible Medical Expenses incurred by the Participant's or former Participant's Dependents to the extent provided by, and in accordance with, the terms of the applicable Incorporated Document(s).
- I. Discrimination Prohibited. The HRA Program is intended to qualify as a medical expense reimbursement plan under Code Section 105 and will be interpreted and administered in accordance with that Code Section and the Regulations thereunder. The HRA Program will not discriminate in favor of Highly Compensated Individuals as to eligibility to participate and the benefits provided will not discriminate in favor of Highly Compensated Individuals who are Participants, in accordance with Code Section 105.
- J. Correcting Discrimination. If the Administrator determines that any of the nondiscrimination requirements above will not be satisfied, the Administrator may, in its discretion, limit reimbursements to Highly Compensated Individuals or treat reimbursements to Highly Compensated Individuals as taxable compensation in order to ensure compliance with these requirements. Any such

action will be carried out in a uniform and nondiscriminatory fashion and may include one or more Highly Compensated Individuals.

- K. Recovery of Excess Reimbursements. Notwithstanding any other provision in the Plan or the HRA Program, the Administrator may pursue such remedies as are available under applicable state and federal law to recover any amounts paid to or on behalf of a Participant in HRA Program which exceed the total amount credited to the Participant's HRA (or Limited-Purpose HRA, if applicable).

- L. Reimbursements from Employer's General Assets. All amounts payable under the HRA Program will be paid exclusively from the Employer's general assets and debited against the Participant's HRA (or Limited-Purpose HRA, if applicable). Nothing in this Article V will be construed to require the Employer or Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person will have any claims against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under the HRA Program may be made. There is no trust or other fund from which reimbursements under HRA Program are paid.

ARTICLE VI

ADMINISTRATION

Section 6.1 Administrator. Except for the functions reserved under the Plan to the Employer, the administration of the Plan shall be under the supervision of the Administrator, who shall be a "named fiduciary" under ERISA. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, for the exclusive benefit of Employees eligible to participate. The Administrator shall have the discretionary authority to interpret the Plan and any related documents (including, but not limited to, any applicable SPD, Incorporated Document, or any other material, except as otherwise provided in any Incorporated Document), and to decide any and all matters arising thereunder, including, but not limited to, matters relating to eligibility for benefits and the construction of the terms of the Plan (including any uncertain or disputed term or provision of the Plan). The Administrator shall have full power to administer the Plan and all of its details, subject to applicable requirements of law. The Administrator shall have the power to delegate one or more of its powers to others, including vendors to the Plan, to the extent permitted by law. The Administrator's powers shall include, but not be limited to, the following:

- A. To interpret the Plan (including questions of fact), decide questions of eligibility of any person to participate in the Plan (or in any Benefit offered by the Plan), exercise discretion and determine the amount, manner and time of payments of any benefits payable under the Plan (or under any Benefit offered by the Plan), its interpretation thereof in good faith to be final and conclusive on all persons, including persons claiming benefits under the Plan;
- B. To establish the method of accounting for the Plan and to maintain the accounts;
- C. To prescribe any forms as it deems necessary or desirable for the efficient administration of the Plan;
- D. To make, enforce and carry out such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of the Plan or law, and to review any prior benefit claim determination made under the Plan unless the authority or responsibility to do so shall be vested in another party;
- E. To appoint individuals or entities (including any office, department or other personnel of the Employer) to assist in the administration of the Plan and any other agents as it deems advisable, including legal, administrative, accounting and actuarial counsel;
- F. To furnish the Employer, upon request, such reports with respect to the administration of the Plan as are reasonable and appropriate;
- G. To receive, review and keep on file (as it deems convenient and proper) reports of benefit payments by the Employer and reports of disbursements for expenses;
- H. To receive from the Employer and from Participants such information as it deems necessary or proper for the efficient administration of the Plan;

- I. To require Participants to complete and file applications for benefits under the Plan, or any other form that the Administrator considers necessary or proper, and to require a Participant to furnish all pertinent information and documents, including receipts for expenses to be reimbursed. The Administrator shall be entitled to rely upon all such information that is furnished, including the Participant's current mailing address;
- J. To take such actions (with the consent and at the direction of the Employer) as it considers necessary or appropriate to satisfy any nondiscrimination requirements of the Code which are applicable to the Plan;
- K. To make Plan corrections permitted under Department of Labor or Internal Revenue Service guidelines, if any, including but not limited to the Delinquent Filer Voluntary Compliance Program or the Voluntary Fiduciary Correction Program, as applicable, or using methods that comply with ERISA and the Code and that are reasonable, practicable and appropriate in the circumstances;
- L. To engage the service of agents whom it may deem advisable to assist it with the performance of its duties; and
- M. Take any and all actions required to comply with the reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

Section 6.2 Committee Procedures. The Committee shall act by majority vote either at a meeting of the Committee or by a written consent (including consent via email). Meetings may be attended telephonically.

Section 6.3 Rules and Decisions. The Committee may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Committee shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Committee shall be entitled to rely upon information furnished by a Claimant, the Employer or Administrator, or the legal counsel of the Employer.

Section 6.4 Examination of Records. The Administrator shall make available to each Participant such records under the Plan as are required by law to be provided or made available, for examination at reasonable times during normal business hours.

Section 6.5 Information Required for Plan Administration. Participants and other persons entitled to benefits under the Plan shall furnish the Administrator with such evidence, data or information as may reasonably be requested from time to time for the purpose of the Plan's administration, and the Administrator shall be entitled, to the extent permitted by law, to rely on all such information provided. If a Participant or other person fails or refuses to provide such information, his or her entitlement to benefits under the Plan may be delayed, suspended or terminated, as appropriate for the circumstances and as determined by the Administrator in its sole discretion.

Section 6.6 Reliance. In administering the Plan, the Administrator shall be entitled to rely exclusively (to the extent permitted by law) upon information, tables, valuations, certificates and reports furnished by or in accordance with the instructions of a Participant, the Employer, the legal, accounting and actuarial counsel of the Employer and the administrators of any insurance companies or other such entities.

Section 6.7 Facility of Payment. When a person entitled to a benefit under the Plan is under a legal disability, or, in the opinion of the Administrator, is in any way incapacitated so as to be unable to manage his or her financial affairs, the Administrator may direct the payment of benefits to such person's legal representative, or to an immediate relative of such person for such person's benefit, or the Administrator may direct the application of such benefits for the benefit of such person in such manner as the Administrator considers advisable. The Administrator need not require the appointment of a guardian or custodian to direct the payment of benefits. Any payment made in accordance with this Section shall be a full and complete discharge of any liability for such payment under the Plan.

Section 6.8 Compensation of Administrator and Committee. All usual and reasonable expenses of the Administrator and the Committee, if any, shall be paid by the Employer, unless the Employer determines that administrative expenses shall be borne by Participants or by any trust fund that may be established in connection with the Plan. In the event the Employer is serving as the Administrator, the Employer shall serve without compensation for services rendered in such capacity. Furthermore, any employee of the Employer shall not receive any compensation with respect to services hereunder except as such person may be entitled to benefits under this Plan.

Section 6.9 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner.

Section 6.10 Employer's Protective Clauses. Upon the failure of either the Participant or the Employer to obtain any 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, 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.

The Employer's liability to the Participant shall only extend to and shall be limited to any payment actually received by the Employer from the insurer. In the event that the full insurance benefit contemplated is not promptly received by the Employer within a reasonable time after submission of a claim, then the Employer shall notify the Participant of such facts and the Employer shall no longer have any legal obligation whatsoever (except to execute any document called for by a settlement reached by the Participant). The Participant shall be free to settle, compromise or refuse to pursue the claim as the Participant, in his or her sole discretion, shall see fit.

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 or arrangement, or for the action of any person which may delay or render null and void or unenforceable, in whole or in part, an insurance contract or arrangement. With regard to this paragraph, the following shall apply:

- A. 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.
- B. To the extent premium notices are received by the Employer, the Employer's liability for the payment of such premiums shall be limited to the amount of such

premiums and shall not include liability for any other loss which may result from the failure to pay such premiums.

- C. The Employer shall not be liable for the payment of any insurance premium or any loss which may result from the failure to pay an insurance premium if the Contributions available under this Plan are insufficient to provide for the amount of such premium cost at the time it is due. In such circumstances the Participant shall be responsible for and see to the payment of such premiums. The Employer shall undertake to notify a Participant if available Contributions under this Plan are insufficient to provide for an insurance premium but shall not be liable for any failure to make such notification.

Section 6.11 Judicial Review of Decision by the Administrator or the Committee. Any interpretation, determination or other action of the Administrator or the Committee authorized and undertaken hereunder shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Administrator or the Committee shall be based only on such evidence presented to or considered by the Administrator or the Committee at the time it made the decision that is the subject of such review. Accepting any benefits or making any claim for benefits under the Plan constitutes agreement with and consent to any decisions that the Administrator or the Committee make, in their discretion, respectively, and further, to the extent permitted by applicable law, constitutes agreement to the limited standard and scope of review described in this Section.

Section 6.12 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 or Optional Benefit Program, such Participant shall indemnify and reimburse the Employer for any such amounts, including any liability the Employer 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 taxes actually paid by the Participant.

Section 6.13 Claims and Review Procedure. The determination of a Claim for Benefits and the rights of Claimants to appeal from adverse Claims decisions shall be determined in accordance with rules under ERISA, as in effect at the time the Claim is being decided. If any Participant or Dependent or beneficiary of a Participant believes he is being denied any rights or Benefits under the Plan after filing a Claim for such Benefits under the applicable Benefit program or with the applicable Benefit provider or administrator, such person may generally file an appeal of such Claim denial in writing in accordance with the Claims procedures applicable to the Benefit in question as set forth in the appropriate Incorporated Document, if any. If Claims procedures do not exist in the specific Benefit program, a Participant, Dependent or other beneficiary may file a Claim using the following procedures. For purposes of the Claim and appeal procedures described below, an "authorized representative" of the Participant, Dependent or other beneficiary may also submit or appeal a Claim on behalf of the Participant, Dependent or other beneficiary.

- A. Definitions. The following definitions apply for purposes of this Section 6.13 only. Other defined terms retain their meaning as described in Article II.

1. Claim. A request for a Plan Benefit or Benefits made by a Participant, covered Dependent or other beneficiary in accordance with the Plan's reasonable procedures for filing Benefit Claims. In the case of a program providing group health Benefits, a Claim for Benefits includes Medical Benefit Claims, Pre-Service and Post-Service Claims.
2. Medical Benefit Claim. A Claim for medical care (as defined in ERISA Section 733(a)) under a group health Benefit program.
3. Post-Service Claim. Any Medical Benefit Claim that is not a Pre-Service Claim.
4. Pre-Service Claim. A request for approval of a Medical Benefit Claim where the receipt of the Benefit is conditioned, in whole or in part, on approval in advance of obtaining medical care.
5. Relevant. A document, record or other item is deemed to be "Relevant" if: (a) such item was used in making the Benefit determination or was submitted in the course of the Claim even if the item was not relied upon in making the Benefit determination; (b) such item demonstrates compliance with the administrative processes and safeguards that confirm that Benefit conclusions are made consistently and in accordance with Plan documents and procedures; or (c) for group health and disability Benefit programs, provides any information regarding a policy or guidance regarding the Claim denial, regardless as to whether such policy or guidance was used in the Claim determination.
6. Urgent Care Claim. A Claim for medical care or treatment where a delay in making a Claim determination could jeopardize the life or health of the Participant or covered Dependent or the ability of such person to regain maximum function, or, in the opinion of a physician knowledgeable about such individual's medical condition, would subject such person to severe pain that cannot be adequately managed without the treatment that is the subject of the Claim.

In making the decision as to whether a Claim involves Urgent Care, the Plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If, however, a physician with knowledge about the Participant or covered Dependent's condition states that the Claim is an Urgent Care Claim, the Claim must be treated as such.

- B. Claims Denial Notification. If a Claim is wholly or partially denied, the Administrator will notify such person of its decision either in writing or electronically, pursuant to Department of Labor Regulation Sections 2520.104b-1(c)(i), (iii) and (iv). Such notification will be in a manner calculated to be understood by the Claimant and will contain the following:
1. Specific reasons for the denial;

2. Specific reference to pertinent Plan provisions on which the decision is based;
3. A description of any additional material or information necessary for such person to perfect the Claim, including an explanation of why such material or information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA;
5. For a denial of Medical Benefit Claims and disability Claims, any information regarding an internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination and either the specific information or a statement indicating that a copy of the information will be provided free of charge upon request;
6. For a denial of Medical Benefit Claims and disability Claims, if the denial is based on medical necessity, experimental or investigational treatment or a similar exclusion or limit, the notice shall include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request. In addition, if the denial is of an Urgent Care Claim, a description of the expedited review process must be provided. Further, information regarding the benefit denial may be provided orally, within the time period described in Section C.1.c. below, provided that written or electronic notification follows not later than three (3) days after the oral notification;
7. For a denial of Medical Benefit Claims, information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes (along with the corresponding meaning or these codes);
8. For a denial of Medical Benefit Claims, the denial code, if any, and its corresponding meaning and a description of the standard, if any, that was used in denying the claim; and
9. For a denial of Medical Benefit Claims, a description of available external review processes, including instructions on how to initiate an appeal.

C. Timeframes for Claim Notification. Notification of a Claim decision will be given within the following timeframes after the Claim is received by the Administrator.

1. Medical Benefit Claims.
 - a. Pre-Service Claims. The Administrator shall notify the Claimant of the decision (whether adverse or not) within a reasonable time, but not later than 15 days after receipt of the Claim. This period may be extended one time by the Plan for up to an additional 15

days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and also notifies the Claimant prior to the end of the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan expects to make a decision. If the extension is due to the failure of the Claimant to submit information necessary to make the decision, the notice of extension shall describe the required information and the time period for deciding the Claim will be suspended until the earlier of (i) the date the Claimant responds to the notice or (ii) after such person is afforded at least 45 days from receipt of the notice to provide the specified information.

- b. Post-Service Claims. The Administrator shall notify the Claimant of an adverse Benefit decision within a reasonable time, but not later than 30 days after receipt of the Claim. The period may be extended one time for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies such person prior to the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to make a decision. If the extension is due to the failure of the Claimant to submit information necessary to make the decision, the notice of extension shall describe the required information and the time period for deciding the Claim shall be suspended until the earlier of (i) the date the Claimant responds to the notice or (ii) after such person is given at least 45 days from receipt of the notice to provide the specified information.
- c. Urgent Care Claims. The Administrator shall notify the Claimant of the decision (whether adverse or not) not later than 72 hours (effective January 1, 2011, 24 hours or such later date required by applicable law) after the receipt of the Claim, unless such person does not provide adequate information to determine whether, or to what extent, benefits are covered or payable under the Plan. If such failure occurs, the Administrator shall notify the Claimant of the deficiency and the information needed to complete the Claim as soon as possible, but not later than 24 hours after receipt of the Claim by the Plan. The Claimant must be allowed a reasonable amount of time, but not less than 48 hours, to provide the information. The Administrator shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no event later than 48 hours after the earlier of (i) the Plan's receipt of the specified information, or (ii) the end of the period afforded to the Claimant to provide the additional information (a minimum of 48 hours).
- d. Ongoing Treatment. If ongoing treatment (i.e., treatment over a period of time or a specified number of treatments) has previously been approved by the Plan, any reduction or termination of the

ongoing treatments will constitute an adverse benefit determination and the Administrator must notify the Claimant within a reasonable time prior to the reduction or termination. In addition, if a Claimant requests to extend Urgent Care treatment beyond a period of time or number of treatments previously approved, the Administrator shall notify such person as soon as possible, but not later than 24 hours following receipt of the Claim, provided that the request is made at least 24 hours in advance of the expiration of the ongoing treatment. If the Claim is not made at least 24 hours in advance of the expiration of the ongoing treatment, then the time frames for Urgent Care Claims generally apply, as set forth above. If a request to extend ongoing treatment does not involve Urgent Care, then the request will be treated as either a new Pre-Service or Post-Service Claim, whichever is applicable.

e. Failure to Follow Procedures. For Pre-Service and Urgent Care Claims described above, if it appears that a Participant, beneficiary or authorized representative is attempting to file a Claim, but has not followed proper procedures, including prior authorization requirements, if applicable, then such person must be notified of his or her failure to file a Claim and the proper procedures to be followed. This notification is required if the communication is received by the individual or group that customarily handles benefit matters and the communication contains the specific Claimant, the symptom and the medical treatment requested. The notification must be provided not later than five (5) days for non-urgent Claims and not later than 24 hours for Urgent Care Claims. Notification may be given orally unless written notification is requested.

2. Disability Benefits. The Administrator shall notify the Claimant of a disability Claim denial within a reasonable period of time, but not later than 45 days after receipt of the Claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant prior to the end of the initial 45-day period of the circumstances requiring the extension of time and the date by which the Plan expects to make a decision. If, prior to the end of the first 30-day extension period, the Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be made within the extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Administrator notifies the Claimant prior to the end of the first 30-day extension period of the circumstances requiring the extension and the date as of which the Plan expects to make a decision. All extension notices shall specifically explain the standards on which entitlement to a Benefit is based, any unresolved issues that prevent a decision to be made on the Claim and the additional information needed to resolve the issues. The Claimant shall be given at least 45 days to provide the necessary information.

3. **Other Claims.** For all Claims other than Claims for disability Benefits and Medical Benefit Claims, the Administrator must notify the Claimant within 90 days. An extension of up to an additional 90 days is available, provided special circumstances require such an extension and if written notice of the extension is given to the Claimant within the initial 90-day period. The notice of extension shall indicate the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
 4. **Deemed Denial.** If notification, as described above, is not given within the applicable time period, the Claim will be considered denied as of the last day of such period and such person may request a review of his or her Claim.
- D. **Appeal.** Within 180 days after the date a Claimant receives a written notice of a denial of a Medical Benefit Claim or disability Claim (or, if applicable, within 180 days after the date on which such denial is considered to have occurred) or within 60 days for all Claims other than Claims for disability Benefits and Medical Benefit Claims such person may:
1. File a written request with the Administrator for a review of the denied Claim. Urgent Care Claims, however, may be submitted either orally or in writing;
 2. Submit written issues, comments, documents, records or other information relating to the Claim to the Administrator and to present evidence or testimony;
 3. Upon request, and free of charge, be provided reasonable access to and copies of all documents, records and other information Relevant to the Claim;

In addition to Items 1 – 3 above, for Medical Care Claims and disability Claims, the Claims appeal process must also:

4. Provide that the review on appeal does not take into consideration the initial Claim determination and that the review be completed by a named fiduciary of the Plan that is neither the individual that made the original Claim denial or the subordinate of such individual;
5. If the decision is based in any way on medical judgment, including any decisions based on whether the treatment, drug or other item is not medically necessary, experimental or investigational, the named fiduciary will consult with a health care professional knowledgeable about such matters and such health care professional is not permitted to be an individual that was initially consulted with respect to the Claim or the subordinate of such individual;
6. Identify the medical or vocational experts that were consulted with regard to the Claim, regardless as to whether their advice was relied upon in making the determination; and

7. Provide that Medical Benefit Claims that are Urgent Care Claims have an expedited review process whereby the request for an expedited appeal may be made orally or in writing by the Claimant and all necessary information regarding the Claim appeal must be transmitted in an expedited manner including, but not limited to, the telephone or facsimile.

The Claims review will take into account all information provided by the Claimant regardless as to whether the information was submitted initially or supplemented at a later time.

- E. Appeal Notification. The Administrator will notify Participants and beneficiaries of its decision in writing or via electronic means, in accordance with Department of Labor Regulation Section 2520.104b-1(c)(1)(i), (iii) and (iv). The decision will generally be made within the following timeframes after the request for review is received by the Administrator:

1. Medical Benefit Claims.

- a. Pre-Service Claims. The Administrator shall notify the Claimant within a reasonable time period, but not later than 30 days after the receipt of the request for review. If there are two (2) levels of appeal, for each level of appeal the Administrator shall notify the Claimant within a reasonable time period, but not later than fifteen (15) days after receipt of the request for review.
- b. Post-Service Claims. The Administrator shall notify the Claimant within a reasonable time period, but not later than 60 days after receipt of the request for review. If there are two (2) levels of appeal, for each level of appeal the Administrator shall notify the Claimant within a reasonable time period, but not later than thirty (30) days after receipt of the request for review.
- c. Urgent Care Claims. The Administrator shall notify the Claimant as soon as possible, but not later than 72 hours after receipt of the request for review.

2. Disability Claims. The Administrator shall notify the Claimant within a reasonable time, but not later than 45 days after receipt of the request for review, unless the Administrator determines that special circumstances require an extension. If an extension is necessary, the Administrator shall provide written notice to the Claimant prior to the expiration of the initial 45 day time period. The notice must include the circumstances that require the extension and the date by which a decision will be made. The extension may not exceed 45 days from the end of the initial 45-day period.

3. Other Claims. For all Claims other than Claims for disability Benefits and Medical Benefit Claims, the Administrator shall notify the Claimant within a reasonable time, but not later than 60 days after receipt of the request for review, unless the Administrator determines that special circumstances require an extension. If an extension is necessary, the

Administrator shall provide written notice to the Claimant prior to the expiration of the initial 60 day time period. The notice must include the circumstances that require the extension and the date by which a decision will be made. The extension may not exceed 60 days from the end of the initial 60-day period.

- F. Claim Denial Notification on Appeal. The Claim denial will be set forth in a manner designed to be understood by the Claimant and will contain the following:
1. The specific reason(s) for the decision;
 2. Specific references to pertinent Plan provisions;
 3. A statement that the Claimant may have access to or receive, upon request and free of charge, copies of all documents, records and other information Relevant to the Claim;
 4. A statement describing any voluntary appeal procedures offered by the Plan, including the Claimant's right to bring an action under Section 502(a) of ERISA;
 5. For denied Medical Benefit claims and disability Claims on appeal, information regarding any internal rule, guideline or protocol that was used in making the Claim determination or a statement indicating that a copy of such information will be supplied free of charge upon request; and
 6. For denied Medical Benefit claims and disability Claims on appeal, an explanation of the scientific or clinical judgment for a Claim denial including applying the terms of the Plan to the request if the determination was based on medical necessity, experimental treatment or some other exclusion limitation. In lieu of providing such information, a statement that a copy of the information will be supplied free of charge upon request may be provided.

If the decision on review is not made within the applicable time period, the Claim appeal will be considered denied. The Administrator or an Incorporated Document may permit additional voluntary levels of appeal.

In addition to the above, the Administrator must provide a Claimant, free of charge, any new or additional evidence considered, relied upon, or generated by the Administrator (or at the direction of the Administrator) in connection with the Claim appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Administrator's notice of its decision on a Participant's or beneficiary's Claim appeal must be provided so that the Claimant has a reasonable opportunity to respond prior to that date. In addition, if the Administrator's Claim appeal decision is based on a new or additional rationale from the initial Claim decision, the Claimant will be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the Administrator's notice of its decision on the Participant's or beneficiary's Claim appeal must be provided so that the Claimant has a reasonable opportunity to respond prior to that date.

- G. **External Review.** The Plan will also institute an external review process for group health plan Claim reviews and appeal denials that involve medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer, or rescission of coverage, in compliance with applicable guidance issued under the Patient Protection and Affordable Care Act, as amended. Such external review process shall be as set forth in the applicable Incorporated Documents.
- H. **Calculating the Time Periods.** The period of time within which a Benefit determination must be made for both initial benefit determinations, determinations on appeal, and determinations on external review begins at the time a Claim is filed in accordance with the Plan procedures, regardless as to whether all the information necessary to decide the Benefit claim accompanies the filing. If the period of time is extended, as described above exclusively due to the failure of a Claimant to submit information necessary to decide the Claim, the period for making the Benefit determination is 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, for initial benefit determinations only, if earlier, after the expiration of 45 days.
- I. **Statute of Limitations for Civil Actions.** For purposes of filing any civil action against the Plan upon the exhaustion of all other available administrative remedies, including under Section 502(a) of ERISA, legal action may be brought no later than one year from the date of completion of the Plan's claims appeal process, or if earlier, three years from the time proof of loss for the applicable Benefit is required under the applicable Incorporated Document or elsewhere in the Plan (e.g., Section 5.3.H. or 5.4.D.). If a proof of loss timeframe does not otherwise exist under the applicable Incorporated Document(s), the proof of loss timeframe will be deemed to be a submission within 90 days following the date the Participant experiences an event entitling him or her to the applicable Benefit under the Plan.

Section 6.14 Questions Relating to Coverage. All questions relating to whether an individual is a Participant or is eligible to become a Participant under this Plan shall be submitted to the Administrator. The Administrator shall determine such questions in its discretion based on its review and interpretation of the terms of this Plan.

Section 6.15 Coordination of Benefits. To minimize claims paid by the Plan, benefits for medical and health care related expenses payable under this Plan will be coordinated with amounts payable under other plans. If coordination of benefits procedures do not exist in the specific Benefit program or applicable Incorporated Document, the Plan shall use the following procedures:

- A. This Plan will coordinate its benefits with the following types of programs:
 - 1. Group or blanket insurance coverage;
 - 2. Group hospital service prepayment plans, group medical service prepayment plans, and group practice or other group pre-payment programs;

3. Labor-management trustee plans, union welfare plans, Association organization plans, employee organization plans, or other employee benefit plans; and
4. Government programs or coverage required or provided by law (including Medicare and no-fault automobile insurance).

This Plan does not coordinate its benefits with an individual, privately-paid insurance plan other than no-fault automobile insurance.

B. The following rules are used to establish the order of benefit determination:

1. The following plans will automatically be the primary plan:
 - a. A plan that does not have a coordination of benefits provision;
 - b. A program or plan that coordinates benefits according to different rules;
 - c. A program or plan required by law, such as Workers' Compensation; or
 - d. A no-fault motor vehicle insurance or third party liability policy.
2. This Plan is the primary plan for all Participants covered by the Plan because they are employees of a participating Employer. Similarly, any other plan or program that covers an individual as an employee will pay benefits before a plan covering the same person as a dependent.
3. For Dependent children, if both parents are enrolled in employer-sponsored health plans that cover their children as dependents:
 - a. The plan of the parent whose birthday is earliest in the year will be the primary plan;
 - b. If both parents have the same birthday (not taking the year into consideration), the plan that has covered the child for the longest period of time will be the primary plan; or
 - c. If the other parent's plan coordinates its benefits according to the gender rule, the father's plan will be primary.
 - d. If the parents of a Dependent child are divorced or separated:
 - (i) If a court decree places financial responsibility for health care expenses on either parent, then that parent's plan will be the primary plan.
 - (ii) If a court decree does not place financial responsibility for health care expenses on either parent:

- (a) The custodial parent's plan will be the primary plan; or
 - (b) If the custodial parent has remarried, the custodial parent's plan shall be the primary plan, the stepparent's plan shall be the secondary plan; and then the non-custodial parent's plan will determine its benefits, if any.
- 4. The plan covering a person as an active employee (or Dependent of an active employee) will pay its benefits before the plan that covers the person as a laid-off or retired employee (or Dependent of a laid-off or retired employee).
- 5. If none of the above rules determine the order of benefit payment, the plan which has covered the individual for the longest period of time will be the primary plan.

C. In determining the amount the Plan will pay when coordinating benefits:

- 1. If this Plan is the primary plan, it will determine its benefits without regard to any other plan or program.
- 2. If this Plan is the secondary plan, it will pay benefits in accordance with one of the methods set forth below for coordination of benefits as elected by the Employer and submitted in writing to the claims administrator, subject to all conditions, limitations and maximum benefit payments that are part of the Plan.
 - a. The Plan will always pay either its regular benefits in full if it is determined to be the primary plan or, under the carve-out method if the Plan is determined to be the secondary plan, a reduced amount which, when added to the benefits payable by the primary plan, will equal no more than the maximum covered expense under this Plan.
 - b. This Plan will always pay either its regular benefits in full if it is determined to be the primary plan or, under the exclusion method, if the Plan is determined to be the secondary plan, the Plan will pay up to the maximum coverage percentage applicable under the applicable Benefit program of the remaining usual, customary and reasonable balance.

Benefits payable under this Plan will be reduced so that the sum of the reduced benefits paid by it and the payments made by all other applicable plans do not exceed the total, actual charge. Plan benefits will be calculated on the assumption that claims have been filed with all applicable plans or programs.

When benefits are coordinated under this provision, only the amount actually paid by the Plan (i.e., the reduced amount) will be charged against applicable limits.

- D. For the purposes of determining the applicability of and implementing the terms of this provision, the claims administrator may release or obtain any information about any person, which the claims administrator considers necessary for these purposes without obtaining permission from the Participant as long as such disclosure is made in accordance with the provisions of Section 6.17 of the Plan (the HIPAA privacy rules), if applicable. Any person claiming benefits under the Plan shall furnish information and execute documents as requested by the claims administrator.

Whenever payments which should have been made under the Plan in accordance with this provision have, in fact, been paid by some other plan or program, the claims administrator will have the right to pay over to the paying plan or program any amounts it deems necessary to satisfy the intent of this provision. Any amounts so paid will be in full satisfaction of the Plan's obligations to pay benefits under this provision.

- E. Whenever payments made under this Plan exceed the maximum amount that should have been paid to satisfy this provision, the Plan shall have the right to recover the excess payment from one or more of the following:
1. Any person to, or for, or with respect to whom, the payments were made;
 2. Any insurance association; or
 3. Any other organization.

Section 6.16 Subrogation and Right of Reimbursement. Notwithstanding any other subrogation or right of reimbursement provisions contained in any Benefit or applicable Incorporated Document, if a Claimant shall have any claim, right, or cause of action against any other person for payment of expenses covered under this Plan other than:

- A. Another benefit program as defined in the Coordination of Benefit provisions; or
- B. In the case of an Employee, one or more of his or her Dependents; or
- C. In the case of a Dependent, the Employee upon which he is dependent and any other Dependents of such Employee,

benefits may be withheld under the Plan when a party other than the Participant may be liable for such expenses until such liability is legally determined. In the event of any payment for benefits under the Plan, the Plan shall, to the extent of such payment, be subrogated to all rights of recovery of the Claimant, or any individual who received a payment of benefits on behalf of the Claimant, arising out of any claim or cause of action that may accrue because of the alleged negligent, willful or other conduct of a third party. Any such Claimant hereby agrees to reimburse the Plan for any benefits so paid hereunder, and any out-of-pocket expenses incurred by the Plan, the Administrator, the Committee, Trinity Health, or any participating Employer in pursuing such recovery, out of any monies recovered from such third party as the

result of judgment, settlement or otherwise. This reimbursement obligation is not limited by the stated purpose of the payment from the third party or how it is characterized in any agreement or judgment, and is not subject to offset or reduction by reason of any legal fees or other expenses incurred by the Claimant in securing such recovery. Further, the claimant is not required to be made whole by such recovery prior to the terms of this Section becoming operative and the Plan specifically disavows the make-whole theory or principle. All rights of recovery will be limited to the amount of any payments made under this Plan. By filing a claim for and accepting benefits under this Plan, any Claimant shall be deemed to have consented to such subrogation and right of reimbursement and to have agreed to cooperate with Trinity Health in any respect necessary or advisable to make, perfect or prosecute such claim, right or cause of action, regardless of whether the Claimant chooses to pursue such claim, right or cause of action, and the Claimant shall enter into a subrogation and reimbursement agreement with the Plan upon the request of Trinity Health. This provision shall not apply, however, to a recovery obtained by a Participant from an insurance company on a policy under which such Participant is entitled to indemnity as a named insured person.

The Plan shall have an equitable lien against any right the Claimant may have to recover any payments made by the Plan from any other party. Recovery shall be limited to the amount of payments made from this Plan. The equitable lien also attaches to any right to payment for workers' compensation, whether by judgment, settlement or otherwise, where the Plan has paid expenses otherwise eligible as covered expenses under the Plan prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or programs or the Employer will be deemed to mean that such a determination has been made. This equitable lien shall also attach to the first right of recovery to any money or property that is obtained by anyone (including, but not limited to, the Claimant, the Claimant's attorney, and/or a trust) as a result of an exercise of the Claimant's rights of recovery. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties. At the discretion of the Administrator, the Plan may reduce any future benefit payments otherwise available to the Claimant under the Plan by an amount up to the total amount of reimbursable payments made by the Plan that is subject to the equitable lien. The Plan's provisions regarding subrogation, reimbursement, equitable liens or other equitable remedies are intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

Section 6.17 HIPAA Privacy Compliance. The Plan shall comply with applicable requirements of the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations found at 45 C.F.R. Parts 160 and 164, as amended from time to time, (collectively "HIPAA") with respect to the programs under the Plan which meet the definition of a "group health plan" as defined by HIPAA (including the Medical Programs (including Prescription Drug Programs), Vision Programs, Dental Programs, Health Care Flexible Spending Account Program, HRA Program and Employee Assistance Programs). Accordingly, the Plan is a "Hybrid Entity" as defined in HIPAA Section 164.103 and this Section shall apply only to the following identified health care components: Medical Programs (including Prescription Drug Programs), Vision Programs, Dental Programs, Health Care Flexible Spending Account Program, HRA Program and Employee Assistance Programs under the Plan, and the Plan's workforce, if any, responsible for performing Plan administrative functions for the identified health care components of the Plan. Any terms used in this Section but not defined herein or otherwise defined in the Plan shall have the meaning set forth in HIPAA. Compliance shall include, but not be limited to the following:

- A. Plan Sponsor Uses and Disclosures. The Plan shall establish and determine the permitted and required uses and disclosures of Protected Health Information (“PHI”) by the Plan Sponsor, provided that such permitted and required uses and disclosures may not be inconsistent with the HIPAA regulations.
- B. Plan Sponsor Obligations. The Plan shall disclose PHI to the Plan Sponsor only upon the Plan Sponsor’s agreement that the Plan Sponsor shall:
1. Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
 2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
 3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
 4. Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures permitted by the Plan and HIPAA of which the Plan Sponsor becomes aware;
 5. Make PHI available in accordance with the provisions of HIPAA granting individuals access to their own PHI contained in the Plan’s designated record set;
 6. Make PHI available for amendment by the individual who is the subject of the PHI and incorporate any amendments to such person’s PHI in accordance with relevant HIPAA provisions;
 7. Make available the information required to provide an accounting of PHI disclosures to an individual covered by the Plan in accordance with relevant HIPAA provisions;
 8. Make the Plan Sponsor’s internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
 9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
 10. Provide for adequate separation between the Plan and the Plan Sponsor, as set forth below.

The Plan Sponsor hereby agrees to abide by the above obligations, and has previously certified to the Plan that it has been amended to incorporate the foregoing provisions, and hereby continues such provisions in this amended and restated Plan document.

C. Adequate Separation.

1. Only the following employees or classes of employees under the control of the Plan Sponsor who are responsible for Plan administrative functions shall be given access to the PHI to be disclosed:
 - a. Employees who work in Total Rewards Benefits with specific accountability for the Plan; and
 - b. Employees performing care management activities for the Plan; and
 - c. Clinical Consultants to the Plan.
2. The Plan shall restrict the access to and use by the employees or classes of employees or other persons under the control of the Plan Sponsor listed in Section C.1., above, to plan administrative functions that the Plan Sponsor performs for the Plan.
3. The Plan shall provide an effective mechanism for resolving any issues of noncompliance with the provisions of this Section by the employees or classes of employees or other persons under the control of the Plan Sponsor listed in Section C.1., above.

D. Plan Disclosures. The Plan may:

1. Disclose PHI to the Plan Sponsor for purposes of the Plan's administrative functions that the Plan Sponsor performs consistent with the provisions of this Section;
2. Not permit a health insurance issuer or health maintenance organization ("HMO") with respect to the Plan to disclose PHI to the Plan Sponsor except as permitted by this Section;
3. Not disclose, and not permit a health insurance issuer or HMO to disclose, PHI to the Plan Sponsor as otherwise permitted by this Section unless the disclosure is included in the Plan's Notice of Privacy Practices distributed to Plan Participants; and
4. Not disclose PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

E. Summary Information. The Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
 2. Modifying, amending or terminating the Plan.
- F. Enrollment Information. The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled or has disenrolled from a health insurance issuer or HMO offered by the Plan.
- G. Business Associate Agreements. The Plan hereby authorizes the Plan Sponsor to enter into Business Associate agreements, or amendments to such agreements, on the Plan's behalf, as necessary for the Plan's compliance with HIPAA's Privacy and Security Standards. Any disclosures of PHI to a Business Associate by the Plan or the Plan Sponsor shall be in accordance with the requirement of HIPAA and the terms of the Business Associate Agreement with the party to whom the disclosure is made.

Section 6.18 HIPAA Security Compliance. The Plan shall comply with the applicable requirements of HIPAA's Security Standards and the implementing regulations found at 45 C.F.R. Part 164, as amended from time to time, with respect to the programs under the Plan which meet the definition of a "group health plan" as defined by HIPAA (including the Medical Programs (including Prescription Drug Programs), Vision Programs, Dental Programs, Health Care Flexible Spending Account Program, HRA Program and Employee Assistance Programs). Accordingly, the Plan is a Hybrid Entity as defined by HIPAA and this Section 6.19 shall apply only to the following identified health care components: the Medical Programs (including Prescription Drug Programs), Vision Programs, Dental Programs, Health Care Flexible Spending Account Program, HRA Program and Employee Assistance Programs under the Plan, and the Plan's workforce responsible for performing Plan administrative functions for the identified health care components of the Plan, to the extent electronic protected health information ("EPHI") is created, received, maintained or transmitted by the Plan. Compliance shall include, but not be limited to the following:

- A. Plan Sponsor Obligations. The Plan shall disclose EPHI to the Plan Sponsor only upon the Plan Sponsor's agreement that the Plan Sponsor shall:
1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of EPHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan;
 2. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides EPHI agrees to implement reasonable and appropriate security measures to protect the EPHI and enters into a Business Associate Agreement reflecting such agreement, as applicable; and
 3. Report to the Plan any security incident (as defined by HIPAA) of which the Plan Sponsor becomes aware.

Enrollment, disenrollment and summary health information shall not be subject to these requirements.

- B. Adequate Separation. The Plan Sponsor shall ensure that the requirements herein for adequate separation of employees with and without access to PHI are supported by reasonable and appropriate security measures to the extent the employees or classes of employees or other persons under the control of the Plan Sponsor who are responsible for plan administrative functions shall be given access to EPHI.

Section 6.19 Rescission. The Plan will not rescind a Participant's or Dependent's coverage under a group health plan component of the Plan except in the case of fraud or intentional misrepresentation of a material fact. For purposes of this provision, a rescission is a cancellation or discontinuance of coverage that has a retroactive effect. However, a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage is not a rescission. In the event of fraud or an intentional misrepresentation of a material fact, the Plan will provide at least 30 days' notice to a Claimant before coverage is rescinded.

ARTICLE VII

AMENDMENT AND TERMINATION

Section 7.1 Amendment. Trinity Health reserves the right at any time or times, to amend in whole or in part, any or all of the provisions of this Plan (including the provisions of any Benefit, Incorporated Document or Optional Benefit Program offered under the Plan) with an instrument in writing executed by an officer of Trinity Health, provided that no such amendment shall change the terms and conditions of payment of any benefits to which Participants have become entitled under the Plan, unless such amendment is made to comply with federal, state or local laws or Regulations. Trinity Health shall also have the right to make retroactive any amendment that is necessary to bring the Plan into compliance with ERISA, the Code or Regulations, or other applicable law. In addition, Trinity Health may merge or combine Benefits or Optional Benefit Programs, add additional Benefits or Optional Benefit Programs under the Plan, or separate existing Benefits or Optional Benefit Programs into an additional number of plans or Optional Benefit Programs. No amendment that affects the rights or obligations of the Administrator may be made without the Administrator's consent. Notwithstanding the foregoing, no oral representation shall act to amend the Plan in any manner or at any time.

Section 7.2 Termination. Trinity Health has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but Trinity Health has no obligation whatsoever to maintain the Plan (or any Benefit, Incorporated Document or Optional Benefit Program offered through the Plan) for any given length of time and may discontinue or terminate the Plan (or any Benefit, Incorporated Document or Optional Benefit Program offered through the Plan) at any time without liability, provided that such termination shall not eliminate any obligations of the Employer which have theretofore arisen under the Plan. Upon termination or discontinuance of the Plan or any portion thereof, any elections, reductions or increases in Compensation made pursuant to the Plan shall terminate. In the event of such termination, the assets of the Plan, if any, shall be used to provide benefits to persons who are Participants at such time and to pay administrative expenses of the Plan and benefits offered through the Plan. Any assets remaining after satisfaction of benefits of the Plan shall be used to provide additional nondiscriminatory benefits to Participants of the Plan as the Administrator shall deem appropriate.

Section 7.3 Effective Date of Amendment or Termination. Any amendment or termination of the Plan (or any Benefit or Optional Benefit Program offered through the Plan) shall be effective as of the date that Trinity Health determines.

Section 7.4 Procedure. Amendments to the Plan shall be authorized in accordance with procedures established from time to time by the Benefits Committee. In general, the person appointed as Administrator is authorized to approve amendments concerning administrative matters. The Benefits Committee is authorized to approve amendments having a non-material effect on both the terms and conditions and costs of providing benefits under the Plan. Plan amendments having a material effect on the terms and conditions of benefits offered under the Plan, the cost of providing benefits or the termination of the Plan must be approved by Trinity Health.

ARTICLE VIII

MISCELLANEOUS

Section 8.1 **No Alienation of Benefits.** Except as otherwise provided in an Incorporated Document, no Benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No Benefit under the Plan shall in any manner be subject to the debts, contracts, liabilities, engagements or torts of any person. If any person entitled to Benefits under the Plan becomes bankrupt or attempts to anticipate, alienate, sell, transfer, assign, pledge, encumber or charge any Benefit under the Plan, or if any attempt is made to subject any such Benefit to the debts, contracts, liabilities, engagements or torts of the person entitled to any such Benefit, except as specifically provided in the Plan or an Incorporated Document, then such Benefit shall cease and terminate in the discretion of the Administrator, and the Administrator may hold or apply the same or any part thereof to the Benefit of any dependent or beneficiary of such person, in such manner and proportions as he may deem proper.

Notwithstanding any provision of the Plan to the contrary, Benefits under the Plan may be subject to a Medical Child Support Order, requiring that Benefits be made available under the Plan to an eligible Dependent of an eligible Employee. The Administrator shall establish procedures to determine if a proposed Order is a Qualified Medical Child Support Order ("QMCSO") under ERISA Section 609(a) and applicable Department of Labor Regulations.

Section 8.2 **Benefits Solely from General Assets.** The Benefits provided hereunder may be paid solely from the Employer's general assets. Nothing herein shall be construed to require Trinity Health, the Employer or the Administrator to maintain (or prevent Trinity Health, the Employer or the Administrator from maintaining) any trust, or other similar fund, insurance policy or contract for the benefit of any Participant. No Participant or other person shall have any claim against, right to, or security or other interest in any assets of the Employer or in any trust or other similar fund from which any payment under the Plan may be made.

Section 8.3 **Plan Not a Contract of Employment.** The adoption and maintenance of this Plan shall not constitute a contract of employment with the Employer and does not assure the continued employment of any Employee eligible to participate for any period of time.

Section 8.4 **Limitation of Rights.** Neither the establishment of the Plan nor any amendment thereto will be construed as giving to any Participant or other person any legal or equitable right against the Administrator or the Employer, except as expressly provided herein and by applicable law.

Section 8.5 **Discrimination Prohibited.** The Plan shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate or in favor of Highly Compensated Participants as to Contributions and Benefits to the extent prohibited under ERISA or the Code. In no event shall the Benefits or coverage under an Optional Benefit Program provided to Key Employees under the Plan exceed 25% of the aggregate of such Benefits or coverage provided for all Participants in any Period of Coverage.

If the Employer determines, before or during any Period of Coverage, that the Plan (or any Optional Benefit Program offered through the Plan) may fail to satisfy any non-discrimination requirement or other limitation which is imposed by the Code on the Plan (or any

such Optional Benefit Program) with respect to Highly Compensated Individuals, Highly Compensated Participants or Key Employees, the Administrator (at the direction of and with the consent of the Employer) shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirements or limitations. Such action may include, without limitation, a modification of elections by Highly Compensated Participants or Key Employees with or without the consent of such Participants.

Section 8.6 Addresses, Notice, Waiver of Notice. Each Participant must file with the Administrator, in writing (or such other form permitted or required by the Administrator), his or her post office address and any change of post office address. Any communication, statement or notice addressed to such Participant at his or her last post office address as filed with the Administrator will be binding upon the Participant for all purposes of the Plan, and neither the Administrator nor the Employer shall be obliged to search for or ascertain the whereabouts of any Participant.

Section 8.7 Mistake of Fact. Any mistake of fact or misstatement of fact shall be corrected when it becomes known, and the Administrator or Employer shall make such adjustment as it considers equitable and practical.

Section 8.8 Payments to Beneficiary. Except as provided in any Incorporated Document, any benefits otherwise available or payable pursuant to the Plan to a Participant following the date of death of such Participant shall be paid to his or her designated beneficiary for such Benefits, if any, and if none, to his or her surviving Spouse, or if there is no surviving Spouse, to his or her estate. Any Benefits or payments made pursuant to an insurance contract or arrangement maintained pursuant to this Plan shall be paid in accordance with the terms of such insurance contract or arrangement. Except as otherwise provided in an Incorporated Document, the entry of a decree of divorce shall not automatically revoke a prior written election of a Participant naming such divorced Spouse as a beneficiary. Any designation, change or revocation by a Participant shall be effective only if it is received by the Administrator before the death of such Participant.

Section 8.9 No Guarantee of Tax Consequences. Neither the Employer nor the Administrator makes any warranty or other representation as to whether any payment received under the Plan will be treated as excludable from the Participant's gross income for federal or state income tax purposes. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes.

Section 8.10 Governing Law. This Plan shall be construed and enforced according to the laws of the State of Michigan, except to the extent preempted by federal law, and in accordance with the Code and ERISA.

Section 8.11 Gender and Number. Masculine pronouns include the feminine as well as the neuter gender, and the singular shall include the plural, unless indicated otherwise by the context.

Section 8.12 Headings. The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

Section 8.13 Conflicting Provisions of Incorporated Documents and Optional Benefit Programs. Notwithstanding anything herein to the contrary, the provisions in the Incorporated Documents, which form and constitute the Benefits and Optional Benefit Programs, shall apply in all cases. The provisions of this Plan shall be interpreted to apply in conjunction with and in addition to such provisions. In the event of a direct conflict between the provisions of an Incorporated Document and the provisions of this Plan, the provisions of the Incorporated Document shall prevail.

Section 8.14 Use of Alternative Media. The Administrator may include in any process or procedure for administering the Plan, the use of alternative media, including, but not limited to, telephonic, facsimile, computer, "on-line" through an internet connection to a website, or any other electronic means that are available and permissible for the purpose intended. Use of such alternative media shall be deemed to satisfy any Plan provision requiring a "written" document or an instrument to be signed "in writing" to the extent permissible under the Code, ERISA or other regulations applicable to such "writing." In addition, the Administrator may require that enrollment in any Benefit or Optional Benefit Program be made in an electronic or on-line format, or conversely that such enrollment will be made through the use of paper forms, to the full extent permitted by applicable law.

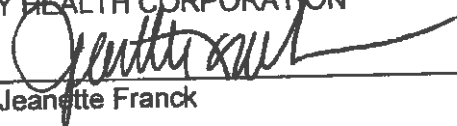
Section 8.15 Lost Participants. Except as otherwise provided in an Incorporated Document, any benefit payment due under the Plan to a Participant shall be forfeited if the Administrator, or the Committee, after reasonable effort, is unable to locate the Participant to whom the benefit payment is due. However, except as otherwise provided in an Incorporated Document, any such forfeited benefit payment will be reinstated and become payable if a valid claim is later made by the Participant or a beneficiary of the Participant, if the Benefit is payable to a beneficiary, for such benefit payment. The Administrator shall prescribe uniform and nondiscriminatory rules for carrying out this provision.

Section 8.16 409A Compliance. It is intended that any severance benefit paid or provided pursuant to the terms of this Plan will not be subject to the additional tax and interest under Code Section 409A. Any severance agreement issued under the Plan will be intended to be exempt from, or to comply with, Code Section 409A, as the Administrator deems appropriate. The Plan and any severance agreement will be interpreted and construed in favor of compliance with any applicable requirements of Code Section 409A as necessary to prevent the imposition of additional or accelerated tax, interest, or penalties under Code Section 409A. Notwithstanding the foregoing, if a severance benefit results in the imposition of additional tax, interest, or penalties under Code Section 409A, the Participant alone shall be liable for any such tax, interest, or penalties and neither the Plan nor Trinity Health as Plan Sponsor guarantees any tax result of any Benefit or Optional Benefit Program under the Plan.

To ensure compliance with Code Section 409A, if at the time of termination of employment with the Employer, an Employee is designated as a "specified employee" (as defined in Code Section 409A) any payments made under the terms of this Plan due to a separation from service (as defined in Code Section 409A) and subject to Code Section 409A shall be delayed until the first business day of the seventh calendar month following the date of separation from service.

[Signature on next page]

TRINITY HEALTH CORPORATION

By: 
Jeanette Franck

Title: Vice President of Total Rewards

Date: December 10, 2013

APPENDIX A - Plan 504

The benefit programs listed below constitute the Benefits and Optional Benefit Programs covered by Plan 504.

A. MEDICAL BENEFIT PROGRAM (including Prescription Drug Program)

Benefits under the Medical Benefit Program (including Prescription Drug Program) are provided through the following:

- High Plan A
- Standard Plan B
- High Plan B
- Healthy Blue Living SI (BCN)
- Healthy Blue Solutions Option B
- Traditional PPO
- Essential PPO
- Healthy Blue Solutions High Option B
- Healthy Blue Living 5
- Priority Health Plan 224
- HealthBy Choice 2
- HealthBy Choice 3
- HealthBy Choice 4
- Advantage Health HMO
- Advantage Health POS
- HAP Health Engagement HMO
- Kaiser HMO Select
- CVS Caremark Prescription Drug Plan
- Med Impact Prescription Drug Plan

HRA Medical Programs

- PCA PPO
- Essential PPO Assist

HSA Medical Program

- Health Savings PPO

B. DENTAL BENEFIT PROGRAM

Benefits under the Dental Benefit Program are provided through the following:

- Delta Dental Premier Standard Dental
- Delta Dental Premier High Dental
- Delta Dental Preferred Standard Dental
- Delta Dental Preferred High Dental
- Delta Dental Clinton Premier Dental
- Delta Dental Dubuque Premier Dental
- Delta Dental Muskegon Premier Dental

C. HRA PROGRAM

APPENDIX B - Plan 505

The benefit programs listed below constitute the Benefits and Optional Benefit Programs covered by Plan 505 (in addition to the provisions of the Plan that establish the Flexible Benefits Program, the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account programs, as applicable). These programs are provided through fully-insured or unfunded arrangements.

A. VISION PROGRAM

Benefits under the Vision Program are provided through the following:

- United Healthcare Vision
- Fresno/San Joaquin Vision Plan (Aetna)

B. LIFE INSURANCE PROGRAM

Benefits under the Life Insurance Program are provided through the following:

- Prudential Basic Life Insurance
- Prudential Optional Life Insurance
- Prudential Dependent Life Insurance
- Unum Basic Life Insurance
- Unum Optional Life Insurance
- Unum Dependent Life Insurance

C. ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PROGRAM

Benefits under the Accidental Death & Dismemberment Program are provided through the following:

- Prudential Basic AD&D Insurance
- Unum Basic AD&D Insurance

D. SHORT-TERM DISABILITY PROGRAM

Benefits under the Short-Term Disability Program are provided through the following:

- Trinity Health STD Plan

E. LONG-TERM DISABILITY PROGRAM

Benefits under the Long-Term Disability Program are provided through the following:

- Hartford Basic LTD Insurance
- Hartford Voluntary LTD Insurance
- Unum Basic LTD Insurance
- Unum Voluntary LTD Insurance

F. HEALTH CARE FLEXIBLE SPENDING ACCOUNT

G. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

H. SEVERANCE PROGRAM

Benefits under the Severance Program are provided through the following:

- Trinity Health Corporation Severance Pay Plan

I. GROUP PRE-PAID LEGAL SERVICES PROGRAM

Benefits under the Life Insurance Program are provided through the following:

- Hyatt legal Plans, Inc.

J. EMPLOYEE ASSISTANCE PROGRAM

APPENDIX C - PARTICIPATING EMPLOYERS

1. **Participating Employers that are Not Affiliated Employers**

Sisters of Mercy Regional Community of Detroit, Inc.
Religious Sisters of Mercy
Sisters of the Holy Cross, Inc.
Holy Cross Sponsored Ministries
The Academy of the Holy Cross, Inc.

2. **Affiliated Employers that are Not Participating Employers**

Mercy Hospital & Medical Center - Chicago
Loyola University Health System and its subsidiaries – Severance Program only
Gottlieb Memorial Hospital and its subsidiaries – Severance Program only
Catholic Health East Corporate Office
All Regional Health Ministries that are or were affiliates and subsidiaries of the legacy Catholic Health East corporate entity

**FIRST AMENDMENT
TO THE
TRINITY HEALTH CORPORATION WELFARE BENEFIT PLAN
(formerly known as the CHE Trinity Welfare Benefit Plan)**

Background Information

- A. Trinity Health Corporation previously adopted and maintains the CHE Trinity Welfare Benefit Plan for the colleagues of the Regional Health Ministries of Trinity Health Corporation that were part of the Trinity Health Corporation health system prior to its becoming a subsidiary of CHE Trinity Inc. on May 1, 2013, and any entity acquired by such a location or Regional Health Ministry of Trinity Health Corporation on or after May 1, 2013, that adopt the Plan and such colleagues' dependents and other beneficiaries;
- B. CHE Trinity Inc., and its subsidiary Catholic Health East, merged into Trinity Health Corporation to become CHE Trinity, Inc., effective as of July 1, 2014.
- C. The name of CHE Trinity, Inc. was changed to Trinity Health Corporation ("Trinity Health"), effective as of November 18, 2014.
- D. On April 9, 2014, the CHE Trinity Inc. Board of Directors (known as the CHE Trinity, Inc. Board of Directors effective July 1, 2014, and the Trinity Health Corporation Board of Directors effective November 18, 2014) ("Board") delegated the responsibility to assist Trinity Health in the administration of all plans of Trinity Health and its related and affiliated entities that are not employee benefit plans intended to qualify as "Church Plans" exempt from the requirements of the Employee Retirement Income Security Act of 1974, ("ERISA"), including the Plan, to the Trinity Health Benefits Committee ("Benefits Committee"), to the extent that such responsibility does not detract from the Benefits Committee's principal purpose of administration and oversight of the employee benefit plans intended to qualify as "Church Plans" exempt from the requirements of the ERISA.
- E. On April 9, 2014, the Board also approved the preparation and adoption of any amendments necessary to the employee benefit plans, including the Plan, to reflect the new governance structure.
- F. Section 7.4 of the Plan authorizes the person appointed as Administrator to approve amendments to the Plan concerning administrative matters.
- G. In accordance with its delegated authority, the Administrator desires to amend the Plan to make certain design changes in order to bring the Plan into compliance with applicable provisions of the Patient Protection and Affordable Care Act and relevant guidance issued thereunder.
- H. In accordance with its delegated authority, the Administrator also desires to amend the Plan to clarify the definition of a "spouse" in order to comply with guidance issued by the Internal Revenue Service in response to the United States Supreme Court's decision in U.S. v. Windsor, which declared Section 3 of the Defense of Marriage Act unconstitutional.

- i. In accordance with its delegated authority and new governance structure approved by the Board, the Administrator further desires to amend the Plan to reflect the Plan's new governance structure, effective as of April 9, 2014, and to change the name of the Plan, effective as of November 18, 2014, to reflect the change in the name of CHE Trinity, Inc. to Trinity Health Corporation.

First Amendment to the Plan

The Plan is hereby amended effective January 1, 2015, unless another effective date is identified herein, as follows:

1. Section 1.1, "Background," is hereby amended by adding the following new fifth and sixth sentences, effective as of November 18, 2014:

"Effective as of July 1, 2014, CHE Trinity Inc. and Catholic Health East merged with and into Trinity Health, which simultaneously changed its name to CHE Trinity, Inc. Effective November 18, 2014, the name of CHE Trinity, Inc. was changed to Trinity Health Corporation ("Trinity Health"). Accordingly, effective November 18, 2014, the name of the Plan is changed to the Trinity Health Corporation Welfare Benefit Plan."

2. Section 2.1, "Administrator," is hereby amended in its entirety to read as follows, effective as of April 9, 2014:

"The person, persons or entity appointed by the Plan Sponsor or the Plan Administrator, in accordance with its delegated authority, from time to time to assist in the day-to-day administration of the Plan. The Plan Sponsor is the "Plan Administrator" and named fiduciary for purposes of ERISA."

3. Section 2.8, "Committee," is hereby amended in its entirety to read as follows, effective as of April 9, 2014:

"Section 2.8 Committee. The Trinity Health Benefits Committee. Consistent with the Trinity Health Corporation Board of Directors Benefits Committee Charter ("Charter") and By-Laws of the Trinity Health Benefits Committee ("By-Laws"), as amended from time to time, which are hereby incorporated herein by reference to the extent applicable: (a) the principal purpose and function of the Committee shall be to oversee the administration of employee benefit plans and programs adopted by Trinity Health and its subsidiaries and affiliates providing benefits to employees throughout the health system and which are exempt from ERISA as church plans, and (b) the Committee shall at all times operate and discharge its responsibilities and authority in a manner that reflects its alignment with the religious bonds and convictions of the Catholic Church. The Committee shall assist the Plan Sponsor in the administration of the Plan, in accordance with its Charter and By-Laws, to the extent it does not detract from the Committee's principal purpose of administration of the church plans. Accordingly, all references in the Plan to the "Plan Administrator," shall be interpreted as references to the Plan Sponsor, as assisted in discharging its duties by the Committee, in accordance with its Charter and By-Laws, but only to the extent it does not detract from the Committee's principal purpose of administration of the church plans."

4. A new last sentence is hereby added to Section 2.34 of the Plan, "Period of Coverage," to read as follows:

"Notwithstanding the foregoing, effective January 1, 2015, the Period of Coverage with respect to a Benefit that is an ACA Group Health Plan, shall be equal to the initial or ongoing stability period for the Participant, without regard to whether such period corresponds to the Plan Year."

5. The first sentence of Section 2.35, "Plan," is hereby amended in its entirety to read as follows, effective as of November 18, 2014:

"The Trinity Health Corporation Welfare Benefit Plan, formerly known as the CHE Trinity Welfare Benefit Plan, as described herein, and as amended from time to time."

6. The following new Section 2.48, a definition of "Affordable Care Act," is hereby added to the Plan to read as follows:

"Section 2.48 Affordable Care Act. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (2010), and as subsequently amended from time to time thereafter."

7. The following new Section 2.49, a definition of "Regional Health Ministry," is hereby added to the Plan to read as follows, effective as of July 1, 2014:

"Section 2.49 Regional Health Ministry. Any one of the regional health systems within the Trinity Health system. Notwithstanding the foregoing, only a Regional Health Ministry that is part of the Trinity Health West/Midwest Group may be a participating Employer and, except where the context indicates otherwise, references in the Plan to "Regional Health Ministry" shall mean a Regional Health Ministry that is part of the Trinity Health West/Midwest Group. The "Trinity Health West/Midwest Group" is comprised of the locations and Regional Health Ministries of Trinity Health that were part of the Trinity Health Corporation health system prior to its becoming a subsidiary of CHE Trinity Inc. on May 1, 2013, and any entity acquired by such a location or Regional Health Ministry of Trinity Health on or after May 1, 2013."

8. Section 3.3, "Effective Date Of Participation," is hereby amended by adding the following new sentence to the end thereof, effective as of January 1, 2014:

"Notwithstanding the foregoing, coverage under a Benefit that is an ACA Group Health Plan for each Employee who is in an eligible group of Employees under the eligibility requirements of the ACA Group Health Plan will be effective no later than the later of: (a) the date that the Employee elects coverage in accordance with the Administrator's policies and procedures; and (b) the 91st day after the Employee becomes a member of the eligible group of Employees under the eligibility requirements of the ACA Group Health Plan, plus any applicable employment-based orientation period not to exceed a length of one month (as determined in accordance with the applicable regulations)."

9. A new last paragraph is hereby added to Section 3.6.C. of the Plan, "Rehired Employees," to read as follows:

"Notwithstanding the foregoing, except as otherwise provided in an Incorporated Document, effective January 1, 2015, if an Employee terminates employment with the Employer and is subsequently rehired by the Employer, for purposes of any Benefit that is an ACA Group Health Plan, the Employee will not be treated as a new Employee and, therefore, will not be required to again meet the requirements of this Article III to the extent required by the rehire rules set forth in the employer shared responsibility provisions of the Affordable Care Act and the guidance issued thereunder and the policies adopted by the Employer and/or Administrator to comply with same. If no such policies have been adopted, for purposes of the ACA Group Health Plans, a rehired Employee will be treated as a new Employee who must again satisfy the requirements of this Article III if the Employee did not have an hour of service for the Employer or an Affiliated Employer for a period of at least 13 consecutive weeks immediately preceding the resumption of services."

10. A new last paragraph is hereby added to Section 3.7 of the Plan, "Termination of Participation," to read as follows:

"Effective January 1, 2015, if a Participant experiences a change in employment status during a Period of Coverage, the Participant will not cease to be eligible to participate in any ACA Group Health Plan until either: (i) the last day of the applicable stability period or (ii) if the Employer elects to begin applying the monthly measurement method in lieu of the otherwise applicable stability period, the first day of the fourth full calendar month following the change in employment status, so long as the Employee was offered "minimum value coverage," within the meaning of the Affordable Care Act, from at least the first day of the month following the Employee's initial three full calendar months of employment through the month in which the change in employment status occurs, and during each of the three full calendar months following the change in employment status the Employee has on average less than 30 hours of service per week."

11. The first sentence of Section 3.14 of the Plan, "Certificates of Coverage," is hereby amended by adding the phrase "Prior to January 1, 2015," to the beginning of such sentence.

12. Section 4.5 of the Plan, "Qualified Change in Status," is hereby amended by adding two new last paragraphs to read as follows:

"In addition to the above, effective January 1, 2015, if a Participant's employment status changes but the employment status change does not cause the Participant to lose eligibility for coverage under a Benefit that is an ACA Group Health Plan, the Participant may revoke or change his (and his Dependents', if any) coverage under the ACA Group Health Plan as well and the corresponding Contributions election under the Plan, within 30 days of the date of his employment status change if the Participant intends to enroll in other health coverage that is "minimum essential coverage," as defined in the Affordable Care Act (e.g., Health Insurance Marketplace coverage or the Participant's Spouse's employer's group health plan or a lower cost group health plan option under this Plan) with the new coverage effective no later than the first day of the second month following the month that includes the date the ACA Group Health Plan coverage is revoked or changed. If the Participant does not complete the proper paperwork or other process

specified by the Administrator to revoke or change his (and his Dependents', if any) ACA Group Health Plan coverage and corresponding Contributions election within 30 days of the date of the Participant's employment status change, the Participant must wait until the next Election Period to revoke or change the ACA Group Health Plan coverage, to be effective at the beginning of the next Plan Year (unless another event occurs which would allow the Participant to revoke or change his coverage prior to such time).

On and after January 1, 2015, a Participant may also cancel his (and his Dependents', if any) ACA Group Health Plan coverage and corresponding Contributions election under the Plan in order to purchase coverage through the Health Insurance Marketplace during a special enrollment period or during the Marketplace's annual enrollment period (i.e., November 15 through the following February 15). In order to cancel ACA Group Health Plan coverage and corresponding Contributions election, the Health Insurance Marketplace coverage must be effective immediately after the day the ACA Group Health Plan coverage is cancelled. A Participant must complete the proper paperwork or other process specified by the Administrator to revoke his (and his Dependents', if any) ACA Group Health Plan coverage and corresponding Contributions election to purchase coverage through the Health Insurance Marketplace during a special enrollment period or during the Marketplace's annual enrollment period."

13. Section 6.1, "Administrator," is hereby amended in its entirety to read as follows, effective as of April, 9, 2014:

"Section 6.1 Committee.

- A. Appointment and Removal of Committee. The members of the Committee shall be appointed by the Board of Directors in accordance with the Benefits Committee's Charter and By-Laws, as amended from time to time, with the advice and consent of Catholic Health Ministries, and shall include at least three (3) members who are designees of Catholic Health Ministries, the sponsor of Trinity Health, including at least one (1) religious member representative of the Mission function within Trinity Health. A member of the Committee may resign by giving at least 30 days advance written notice to the remaining members and to the Chairman of the Board of Directors. If a member resigns or is removed from the position he or she holds that makes the member eligible to serve on the Committee, such member shall automatically be considered also to have resigned from the Committee, effective at the same time as he or she ceases to serve in such qualifying capacity. A member may also be removed, with or without cause, at any time in the discretion of the Board of Directors or, for members who are designees of Catholic Health Ministries or of an officer of Trinity Health who has appointing authority for such position on the Committee, at any time in the discretion of Catholic Health Ministries or the appointing officer. Such removal will be effective upon the giving of notice to the affected member then in office. Vacancies which occur in regular positions on the Committee for any reason shall be filled by the Board of Directors and/or Catholic Health Ministries. Until a replacement for a vacant position is appointed, the remaining members of the Committee shall constitute the entire Committee.
- B. Decisions by Committee. The Committee shall act by majority vote either at a meeting of the Committee or by written consent (including consent via email). Meetings may be attended telephonically.

- C. Authority. For purposes of this Section 6.1.C., whether something is “material” shall be determined in accordance with the Materiality Thresholds and Authorization Limits set forth in the Trinity Health Corporation Table of Authority for welfare Benefit Plans, as amended from time to time (“Table of Authority”). The Committee shall have the following duties and authority under the Plan:
1. Plan Administration - Discretionary Authority. The Committee shall have the full and exclusive discretionary authority to interpret the Plan and any related documents (including, but not limited to, any applicable SPD, Incorporated Document, or any other material, except as otherwise provided in any Incorporated Document), and to decide any and all matters arising thereunder, including, but not limited to, matters relating to eligibility for benefits and the construction of the terms of the Plan (including any uncertain or disputed term or provision of the Plan). The Committee shall have full power to administer the Plan and all of its details, subject to applicable requirements of law. The Committee shall have the power to delegate one or more of its powers to others, including vendors to the Plan, to the extent permitted by law and the Materiality Thresholds and Authorization Limits set forth in the Table of Authority. The Committee shall have overall responsibility for the operation and administration of the Plan and shall have all power and authority to carry out that obligation. It shall supervise the day to day administration of the Plan as conducted by the Administrator as set forth in Section 6.2 or, at its discretion, assume all or any portion of the duties of the Administrator, or delegate all or a portion of such duties to a third party administrator. The Committee may appoint an individual to act as the Administrator and may remove such person as Administrator at any time. The Committee shall determine all Claims Appeals as set forth in Section 6.13.D. of this Plan and shall have the authority to determine all questions of fact relating to such an appeal. Any determination by the Committee pursuant to this Section 6.1.C. or the Claims Procedure shall be binding and conclusive on all parties.
 2. Third Party Administrators. The Committee may appoint one or more third party administrators to provide administrative services to the Plan, to the extent permitted by law and the Materiality Thresholds and Authorization Limits set forth in the Table of Authority. The third party administrators shall be paid such fees and provide such services as may be mutually agreed upon, in writing, by the third party administrator(s) and the Committee. Subject to the terms of any third party administrator agreement, the Committee may remove a third party administrator at any time.
 3. Plan Amendments. The Committee shall have the authority to amend the Plan as set forth in Section 7.1.A. and shall have the authority to recommend material Plan amendments to the Trinity Health Executive Leadership Team (“ELT”) and Board of Directors and recommend Plan termination or suspension to the Board of Directors. Whether the Administrator, the Committee or the ELT must approve such amendment,

shall be determined in accordance with the Materiality Thresholds and Authorization Limits set forth in the Table of Authority.

4. Adoption of Plan – Merger. The Committee may approve an “Institutional Participation Policy” and such other policies and procedures as it determines are appropriate regarding the adoption of the Plan by other employers, approve participation in the Plan by other employers to the extent their participation is not provided for in the Institutional Participation Policy, consent to the withdrawal of a participating Employer from participation in the Plan, and approve exceptions to the Institutional Participation Policy. Notwithstanding the foregoing the ELT shall recommend material Plan participation decisions to the Board of Directors and the Board of Directors shall approve all material Plan participation decisions.
5. Rules and Decisions. The Committee may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Committee shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Committee shall be entitled to rely upon information furnished by a Claimant, the Employer or Administrator, or legal counsel of the Employer.
6. Delegation. The Committee may delegate such of its duties, authority and obligations hereunder to the Administrator, corporate staff, existing committees of the Plan sponsor or its Board of Directors, subcommittees it may form, or third party providers as it may, in its discretion, determine. Any delegation of fiduciary duties hereunder must be approved by a majority of the Benefits Committee. A delegation may be modified or rescinded at any time by further action of the Committee, which shall have an on-going duty to monitor the performance of any fiduciary obligations delegated to others under this provision.
7. Funding. The Committee shall review the Plan funding (i.e., insured, Employer’s general assets or trust) recommended by the Administrator. The ELT shall approve non-material Plan funding decisions and the Board of Directors shall approve all material Plan funding decisions.
8. Auditor. The Committee may appoint an auditor to audit the financial statements of and provide other auditing services to the Plan. The auditor shall be paid such fees and provide such services as may be mutually agreed upon, in writing, by the auditor and the Committee. Subject to the terms of any written agreement with an auditor, the Committee may remove an auditor at any time. The Committee shall also review and accept any annual Plan audit performed by the auditor appointed by the Committee.
9. Plan Design. The Committee shall have the right, at any time, without the consent of the Employers, Participants, Beneficiaries, or any person(s) claiming through them, to determine or change, in whole or in part, the Plan design, to the extent permitted by law and the Materiality Thresholds

and Authorization Limits set forth in the Table of Authority. The Committee and ELT shall recommend material Plan design determination and changes to the Board of Directors and the Board of Directors shall approve all material Plan design determinations and changes. Whether the Administrator, the Committee or the ELT must approve such amendment, shall be determined in accordance with the Materiality Thresholds and Authorization Limits set forth in the Table of Authority.

- D. Designation by Committee. The Committee shall designate one of its members to serve as Chairperson, as well as designate the appropriate officers or other employees who are authorized to sign documents on behalf of the Committee or Trinity Health or to take any other action necessary to implement the decisions of the Committee.

6.2 Administrator. Unless an individual Administrator is appointed by the Committee pursuant to Section 6.1.C.1., the Human Resource Department of the Plan Sponsor, as applicable, shall act as the Administrator. The Administrator shall report to the Committee on a regular basis as the Committee shall direct. The Administrator shall administer the Plan on a day to day basis in accordance with its terms and in accordance with the Code and all other applicable laws and Treasury Regulations except as otherwise expressly provided to the contrary herein. Specifically, but not by way of limitation, the Administrator shall:

- A. Reporting and Disclosure. Comply with the reporting and disclosure requirements of the Code, as applicable, including the preparation and dissemination of disclosure material to the Plan Participants and Beneficiaries and the filing of such necessary forms and reports with governmental agencies as may be required of Church Plans, perform any employee communications required by applicable law and/or that the Administrator considers necessary or proper and take any and all actions required to comply with the reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 and the applicable reporting requirements of the Affordable Care Act and any other applicable law;
- B. Testing. Perform any required nondiscrimination testing and take such actions (with the consent and at the direction of the Employer) as it considers necessary or appropriate to satisfy any nondiscrimination requirements of the Code which are applicable to the Plan;
- C. Plan Interpretation. Except as otherwise provided in an Incorporated Document for a Benefit, interpret the Plan (including questions of fact), decide questions of eligibility of any person to participate in the Plan (or in any Benefit offered by the Plan), exercise discretion and determine the amount, manner and time of payments of any benefits payable under the Plan (or under any Benefit offered by the Plan), its interpretation thereof in good faith to be final and conclusive on all persons, including persons claiming benefits under the Plan;

- D. Procedures and Forms. Establish such administrative procedures and prescribe any forms as it deems necessary or desirable for the proper and efficient administration of the Plan;
- E. Method of Accounting. Establish the method of accounting for the Plan and to maintain the Health Care Expense Accounts, Dependent Care Accounts and HRAs;
- F. Rules and Regulations. Make, enforce and carry out such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of the Plan or law, and to review any prior benefit claim determination made under the Plan unless the authority or responsibility to do so shall be vested in another party;
- G. Claims. Except as otherwise provided in an Incorporated Document for a Benefit, have the discretionary authority to determine all claims filed pursuant to Section 6.13 of this Plan and have the authority to determine issues of fact relating to such claims;
- H. Payment of Benefits. Monitor the payment of Plan benefits;
- I. Compliance Review. Perform an annual compliance review and perform on-going administration compliance reviews as it determines, in its discretion, are necessary;
- J. Plan Participation. Recommend an Institutional Participation Policy for participation in the Plan by employers;
- K. Advisors. Appoint and engage individuals or entities (including any office, department or other personnel of the Employer) to assist in the administration of the Plan and any other agents as it deems advisable to assist it with the performance of its duties, including legal, administrative, accounting and actuarial counsel, and appoint a third party administrator(s) or insurance carrier(s), if applicable, subject to the Materiality Thresholds and Authorization Limits set forth in the Table of Authority;
- L. Reports. Furnish the Employer, upon request, such reports with respect to the administration of the Plan as are reasonable and appropriate and receive, review and keep on file (as it deems convenient and proper) reports of benefit payments by the Employer and reports of disbursements for expenses;
- M. Information. Require Participants to complete and file applications for benefits under the Plan, or any other form that the Administrator considers necessary or proper, require a Participant to furnish all pertinent information and documents, including receipts for expenses to be reimbursed and receive from the Employer and from Participants such information as it deems necessary or proper for the efficient

administration of the Plan. The Administrator shall be entitled to rely upon all such information that is furnished, including the Participant's current mailing address;

- N. Corrections. Ensure that the Plan is administered in accordance with its terms and in compliance with the Code, and any other applicable laws and Treasury Regulations, except as otherwise expressly provided to the contrary herein, and make Plan corrections permitted under Department of Labor or Internal Revenue Service guidelines, if any, including but not limited to the Delinquent Filer Voluntary Compliance Program or the Voluntary Fiduciary Correction Program, as applicable, or using methods that comply with ERISA and the Code and that are reasonable, practicable and appropriate in the circumstances;
- O. Funding. Recommend Plan funding (i.e., insured, Employer's general assets or trust) to the ELT and/or Board of Directors in accordance with the Table of Authority; and
- P. Plan Amendments. In accordance with the Table of Authority, amend the Plan as set forth in Section 7.1.A., recommend Plan amendments to the Committee, ELT or Board of Directors, and recommend Plan termination or suspension to the Board of Directors.
- Q. Plan Design. The Administrator shall have the right, at any time, without the consent of the Employers, Participants, Beneficiaries, or any person(s) claiming through them, to determine or change, in whole or in part, the Plan design, to the extent permitted by law and the Materiality Thresholds and Authorization Limits set forth in the Table of Authority. The Administrator shall recommend Plan design changes to the Committee or Board of Directors, in accordance with the Table of Authority."

14. Section 6.6, "Reliance," is hereby amended in its entirety to read as follows, effective as of April 9, 2014:

"Section 6.6 Reliance. In administering the Plan, the Committee and Administrator shall be entitled to rely exclusively (to the extent permitted by law) upon information, tables, valuations, certificates and reports furnished by or in accordance with the instructions of a Participant, the Employer, the legal, accounting and actuarial counsel of the Employer and the administrators of any insurance companies or other such entities."

15. Section 6.9, "Nondiscriminatory Exercise of Authority," is hereby amended in its entirety to read as follows, effective as of April 9, 2014:

"Section 6.9 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by the Committee or Administrator is required, the Committee or Administrator, as applicable, shall exercise its authority in a nondiscriminatory manner."

16. Section 6.13.D.1. and 2., 6.13.E. and 6.13.F. are hereby amended by replacing "Administrator" each place it appears therein with "Committee," effective as of April 9, 2014.

17. The last paragraph of Section 6.13.F., "Claim Denial Notification on Appeal," is hereby amended in its entirety to read as follows, effective as of April 9, 2014:

"In addition to the above, with respect to a Medical Benefit Claim, the Committee must provide a Claimant, free of charge, any new or additional evidence considered, relied upon, or generated by the Committee (or at the direction of the Committee) in connection with the Claim appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Committee's notice of its decision on a Participant's or beneficiary's Medical Benefit Claim appeal must be provided so that the Claimant has a reasonable opportunity to respond prior to that date. In addition, if the Committee's Medical Benefit Claim appeal decision is based on a new or additional rationale from the initial Claim decision, the Claimant will be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the Committee's notice of its decision on the Participant's or beneficiary's Medical Benefit Claim appeal must be provided so that the Claimant has a reasonable opportunity to respond prior to that date."

18. The fifth sentence of the last paragraph of Section 6.16, "Subrogation and Right of Reimbursement," is hereby amended in its entirety to read as follows, effective as of January 1, 2014:

"This equitable lien shall also attach to the first right of recovery to any money or property that is obtained by anyone (including, but not limited to, the Claimant, the Claimant's attorney, and/or a trust) as a result of an exercise of the Claimant's rights of recovery and shall not be reduced by any attorney fees in connection with said recovery."

19. Article VII, "Amendment and Termination," is hereby amended in its entirety to read as follows, effective as of April 9, 2014:

"7.1 Amendment.

A. Board of Directors, Committee, Administrator and ELT. Except as otherwise provided to the contrary herein, the Board of Directors, Committee, Administrator and ELT shall have the right, at any time, without the consent of a participating employer, Participants, Dependents, beneficiaries or any person(s) claiming through them, to modify or amend, in whole or in part, any or all of the provisions of the Plan (including the provisions of any Benefit, Incorporated Document or Optional Benefit Program offered under the Plan), including specifically the right to make any such amendments effective retroactively to bring the Plan into compliance with the Code or Regulations or other applicable law, in accordance with the Materiality Thresholds and Authorization Limits set forth in the Table of Authority. In addition, the Board of Directors, Committee, Administrator and ELT may merge or combine Benefits or Optional Benefit Programs, add additional Benefits or Optional Benefit Programs under the Plan, or separate existing Benefits or Optional

Benefit Programs into an additional number of plans or Optional Benefit Programs in accordance with the Materiality Thresholds and Authorization Limits set forth in the Table of Authority. No amendment that affects the rights or obligations of the Committee or Administrator may be made without the Committee's or Administrator's, respectively, consent. In general, the person appointed as Administrator is authorized to approve amendments concerning administrative matters. The Committee is authorized to approve amendments having a non-material effect on both the terms and conditions and costs of providing benefits under the Plan. Plan amendments having a material effect on the terms and conditions of benefits offered under the Plan, the cost of providing benefits or the termination of the Plan must be approved by the ELT or Board of Directors in accordance with the Materiality Thresholds and Authorization Limits set forth in the Table of Authority.

- B. Limitations. No Plan amendment shall change the terms and conditions of payment of any benefits to which Participants have become entitled under the Plan, unless such amendment is made to comply with federal, state or local laws or Regulations.
- C. No Oral Amendments. All amendments to the Plan shall be in writing. No oral representations shall be effective to amend the Plan in any manner at any time.

7.2 Termination. The Plan Sponsor has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Plan Sponsor has no obligation whatsoever to maintain the Plan (or any Benefit, Incorporated Document or Optional Benefit Program offered through the Plan) for any given length of time and may suspend, discontinue or terminate the Plan (or any Benefit, Incorporated Document or Optional Benefit Program offered through the Plan) at any time without liability, provided that such suspension, discontinuance or termination shall not eliminate any obligations of the Employer which have theretofore arisen under the Plan. Upon suspension, termination or discontinuance of the Plan or any portion thereof, any elections, reductions or increases in Compensation made pursuant to the Plan shall terminate. In the event of such termination, the assets of the Plan, if any, shall be used to provide benefits to persons who are Participants at such time and to pay administrative expenses of the Plan and benefits offered through the Plan. Any assets remaining after satisfaction of benefits of the Plan shall be used to provide additional nondiscriminatory benefits to Participants of the Plan as the Administrator shall deem appropriate.

7.3 Effective Date of Amendment or Termination. Any amendment or termination of the Plan (or any Benefit or Optional Benefit Program offered through the Plan) shall be effective as of the date that the Board of Directors, Committee, Administrator and ELT, as applicable, determines.

7.4 Procedure. Amendments to the Plan shall be authorized in accordance with procedures established from time to time by the Board of Directors, Committee, Administrator and ELT, as applicable."

20. Section 8.2, "Benefits Solely from General Assets," is hereby amended in its entirety to read as follows, effective as of April 9, 2014:

"Section 8.2 Benefits Solely from General Assets. The Benefits provided hereunder may be paid solely from the Employer's general assets. Nothing herein shall be construed to require the Plan Sponsor, the Employer, the Committee or the Administrator to maintain (or prevent the Plan Sponsor, the Employer, the Committee or the Administrator from maintaining) any trust, or other similar fund, insurance policy or contract for the benefit of any Participant. No Participant or other person shall have any claim against, right to, or security or other interest in any assets of the Plan Sponsor or Employer or in any trust or other similar fund from which any payment under the Plan may be made."

21. Section 8.4, "Limitation of Rights," is hereby amended in its entirety to read as follows, effective as of April 9, 2014:

"Section 8.4 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereto will be construed as giving to any Participant or other person any legal or equitable right against the Plan Sponsor, Committee, Administrator or the Employer, except as expressly provided herein and by applicable law."

22. The first sentence of the second paragraph of Section 8.5, "Discrimination Prohibited," is hereby amended in its entirety to read as follows, effective as of April 9, 2014:

"If the Administrator determines, before or during any Period of Coverage, that the Plan (or any Optional Benefit Program offered through the Plan) may fail to satisfy any non-discrimination requirement or other limitation which is imposed by the Code on the Plan (or any such Optional Benefit Program) with respect to Highly Compensated Individuals, Highly Compensated Participants or Key Employees, the Administrator (at the direction of and with the consent of the Employer) shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirements or limitations."

23. Section 8.7, "Mistake of Fact," is hereby amended in its entirety to read as follows, effective as of April 9, 2014:

"Section 8.7 Mistake of Fact. Any mistake of fact or misstatement of fact shall be corrected when it becomes known, and the Committee, Administrator or Employer shall make such adjustment as it considers equitable and practical."

24. Section 8.10, "Governing Law," is hereby amended by adding the following new sentence to the end thereof, effective as of June 26, 2013:

"Notwithstanding the foregoing, effective June 26, 2013, a Participant's Spouse for Plan purposes shall be determined in accordance with the law of the State or foreign jurisdiction where the Participant and Spouse were married."

25. The following new Section 8.17, "Medical Loss Ratio Rebate," is hereby added to the Plan, effective as of January 1, 2011:

"Section 8.17 Medical Loss Ratio Rebate. To the extent that the Plan, the Plan Sponsor or the Employer, as the policyholder of a group health insurance policy that provides benefits under a Benefit Program, receives a medical loss ratio rebate from a health insurance issuer in accordance with the Affordable Care Act, the rebate will be utilized in accordance with ERISA and the policies and procedures established by the Employer. If there are no such policies and procedures, the rebate will be utilized in any reasonable manner determined by the Administrator in its discretion that complies with ERISA."

26. All other terms and provisions of the Plan shall remain unchanged.

TRINITY HEALTH CORPORATION

By: 

Jeanette Franck

Title: Vice President of Total Rewards

Date: December 22, 2014

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**SECOND AMENDMENT
TO THE
TRINITY HEALTH CORPORATION WELFARE BENEFIT PLAN**

Background Information

- A. Trinity Health Corporation ("Trinity Health") previously adopted and maintains the Trinity Health Corporation Welfare Benefit Plan ("Plan") for the colleagues of the locations and Regional Health Ministries of Trinity Health that were part of the Trinity Health Corporation health system prior to its becoming a subsidiary of CHE Trinity Inc. on May 1, 2013, and any entity acquired by such a location or Regional Health Ministry of Trinity Health Corporation on or after May 1, 2013, that adopt the Plan and such colleagues' dependents and other beneficiaries.
- B. Trinity Health also previously adopted and maintains the Trinity Health East Group Welfare Benefit Plan ("East Group Plan") for the colleagues of the locations and Regional Health Ministries of Trinity Health that were part of the Catholic Health East health system prior to its becoming a subsidiary of CHE Trinity Inc. on May 1, 2013, and any entity acquired by such a location or Regional Health Ministry of Trinity Health Corporation on or after May 1, 2013 (the "Trinity Health East Group"), that adopt the East Group Plan and such colleagues' dependents and other beneficiaries.
- C. Trinity Health desires for the Trinity Health East Group members to become participating employers in the Plan effective as of January 1, 2016, other than the entities that became Trinity Health East Group members pursuant to the Membership Transfer Agreement between Trinity Health Corporation and Saint Francis Care, Inc. or the Affiliation Agreement among Trinity Health Corporation, St. Joseph's Health, Inc. and the St. Joseph's Controlled Subsidiaries, and any entity acquired by such entities.
- D. Trinity Health also desires for Burdett Care Center, Inc. to become a participating employer in the Plan for the period beginning on January 1, 2016 and ending December 31, 2016, but only with respect to the Dental Benefit Program and Vision Program.
- E. Section 7.1 of the Plan authorizes the person appointed as Administrator to amend the Plan in accordance with the Materiality Thresholds and Authorization Limits set forth in the Trinity Health Corporation Table of Authority for Welfare Benefit Plans, as amended from time to time.

Second Amendment to the Plan

The Plan is hereby amended as follows, effective as of January 1, 2016:

1. Section 2.49, the definition of "Regional Health Ministry," is hereby deleted in its entirety to reflect that, as of the effective date of this Amendment, both West/Midwest and East Group employers are Participating Employers except as otherwise provided in Appendix C.

2. Appendix C, "Participating Employers," is hereby amended in its entirety to read as follows:

APPENDIX C - PARTICIPATING EMPLOYERS

1. Participating Employers that are Not Affiliated Employers

Sisters of Mercy Regional Community of Detroit, Inc.
Religious Sisters of Mercy
Sisters of the Holy Cross, Inc.
Holy Cross Sponsored Ministries
The Academy of the Holy Cross, Inc.
Burdett Care Center, Inc. - for the period beginning on January 1, 2016 and ending December 31, 2016 and only with respect to the Dental Benefit Program and Vision Program

2. Affiliated Employers that are Not Participating Employers

Loyola University Health System and its subsidiaries – Severance Program only
Gottlieb Memorial Hospital and its subsidiaries – Severance Program only
Trinity Health East Group members that became Trinity Health East Group members pursuant to the Membership Transfer Agreement between Trinity Health Corporation and Saint Francis Care, Inc. or the Affiliation Agreement between and among Trinity Health Corporation, St. Joseph's Health, Inc. and the St. Joseph's Controlled Subsidiaries, and any entity acquired by such entities

3. All other terms and provisions of the Plan shall remain unchanged.

TRINITY HEALTH CORPORATION

By: Jeanette Franck
Jeanette Franck

Title: Vice President of Total Rewards

Date: 12-29-15

**THIRD AMENDMENT
TO THE
TRINITY HEALTH CORPORATION WELFARE BENEFIT PLAN**

Background Information

- A. Trinity Health Corporation ("Trinity Health") previously adopted and maintains the Trinity Health Corporation Welfare Benefit Plan ("Plan") for the colleagues of Trinity Health and certain of its affiliates, and their eligible dependents and beneficiaries.
- B. Section 7.1 of the Plan authorizes the person appointed as Administrator, currently the Vice President, Total Rewards, to amend the Plan in accordance with the Materiality Thresholds and Authorization Limits set forth in the Trinity Health Corporation Table of Authority for Welfare Benefit Plans, as amended from time to time.
- C. In accordance with her delegated authority, the Administrator desires to amend the Plan to clarify certain provisions regarding health savings accounts and the Health Savings Account Program.
- D. In accordance with her delegated authority, the Administrator further desires to amend the Plan to clarify the coverage period under the Dependent Care Flexible Spending Account Program.
- E. In accordance with her delegated authority, the Administrator further desires to amend Appendices A and B to the Plan to update the Benefits and Optional Benefit Programs incorporated within the Plan, effective as of January 1, 2017.
- F. In accordance with her delegated authority, the Administrator also desires to amend Appendix C to the Plan to clarify the Participating Employers in the Plan, effective as of January 1, 2017.

Third Amendment to the Plan

The Plan is hereby amended as follows, generally effective as of January 1, 2017:

- 1. Section 2.24 of the Plan, "Health Savings Account Program or HSA Program," is hereby clarified by adding the following new provisions to the end thereof:

"In addition, if the Employer limits the qualified trustee(s) and/or custodian(s) to whom it will forward or make Contributions under the HSA Program, an HSA-Eligible Employee must establish an HSA with such a trustee or custodian and provide any verification required by the trustee or custodian prior to the end of a Plan Year in order to receive an Employer Contribution, if any, or make any pre-tax Contributions to his or her HSA for the Plan Year. If the HSA-Eligible Employee fails to establish an HSA with such a trustee or custodian and provide any verification required by the trustee or custodian prior to the end of a Plan Year, any Employer Contribution which would have otherwise been made to his or her HSA for the Plan Year is forfeited. Further, no Employer Contribution will be made to an individual's HSA unless he or she is an HSA-Eligible Employee at the time the Employer Contribution will be made. As a result, no Employer Contribution will be made to an HSA of an individual covered under the Plan as a result of COBRA coverage."

2. The last sentence of Section 5.3.A.5. of the Plan, "Period of Coverage," is hereby deleted in its entirety.

3. The second sentence of Section 5.4.F. of the Plan, "Termination of Participation," is hereby deleted in its entirety and replaced with the following:

"A Participant in the Dependent Care Flexible Spending Account Program may continue to submit claims for reimbursement of Eligible Dependent Care Expenses incurred through the date his or her employment with the Employer terminated and may request reimbursement for such Eligible Dependent Care Expenses through the March 31st following the close of the Plan Year during which the Participant's employment with the Employer terminated (or, if March 31st falls on a Saturday, Sunday or holiday, the next following business day)."

4. The following new Section 6.20, "Assignability," is hereby added to the Plan:

"Section 6.20 Assignability. Except as otherwise specifically provided in an Incorporated Document, no assignment currently in effect or prospective, may be made for the payment of benefits to a provider, including physicians, hospitals or other providers of services covered by the Plan or any Benefit under the Plan. Plan payments to directly to a provider for covered expenses shall not be construed as a waiver of this anti-assignment requirement. Further, any assignment recognized or accepted by the Plan or a Benefit shall be limited to the right to receive payment or benefits for covered expenses and shall not include the right to pursue claims or litigation of any other nature against the Plan, including, but not limited to, fiduciary claims or acting on behalf of a Claimant in pursuing benefit claims under the Plan or a Benefit, or confer to the provider any specific rights under the Plan or ERISA.

5. Appendices A, B and C are hereby replaced by the Appendices A, B and C attached hereto.

6. All other terms and provisions of the Plan shall remain unchanged.

TRINITY HEALTH CORPORATION

By: _____

Jeanette Franck

Title: Vice President, Total Rewards

Date: June 22, 2017

APPENDIX A - Plan 504

The benefit programs listed below constitute the Benefits and Optional Benefit Programs covered by Plan 504.

A. MEDICAL BENEFIT PROGRAM (including Prescription Drug Program)

Benefits under the Medical Benefit Program (including Prescription Drug Program) are provided through the following:

- Traditional PPO
- Health Savings PPO
- Essential PPO
- Essential PPO Assist
- Healthy Blue Solutions Option B
- Healthy Blue Living SI (BCN)
- Healthy Blue Living 5
- Kaiser HMO select
- CVS Caremark Prescription Drug Plan
- CDPHP EPO – Albany
- CDPHP PPO – Albany
- BCBS GA High – Athens
- BCBS GA Low – Athens
- BCBS GA HMO – Athens
- Aetna CDHP – Camden
- Highmark PPO – Pittsburgh
- Highmark HDHP – Pittsburgh
- UMPC PPO – Pittsburgh
- UMPC HDHP – Pittsburgh
- IBC MFH Union High PPO – SEPA union
- IBC MFH Union Low PPO – SEPA union
- IBC MFH Union POSUMPC PPO
- HNE PPO – Springfield FFC union
- HNE EPO – Springfield MNA union
- HNE PPO – Springfield MNA union
- HNE EPO – Springfield
- HNE PPO – Springfield
- Aetna HMO – Atlanta
- BCBS of IL HMO – Mercy Chicago
- BCBS of IL PPO – Mercy Chicago
- BCBS Advantage HMO – Mercy Chicago
- Anthem Lumenos HRA – W. Hartford

HRA Medical Programs

- Essential PPO Assist

HSA Medical Program

- Health Savings PPO

B. DENTAL BENEFIT PROGRAM

- Delta High dental
- Delta Standard dental
- Delta dental Muskegon Premier dental
- UCCI Premier (Mercy Health System of Southeastern Pennsylvania collective bargained employees only)

C. HRA PROGRAM

APPENDIX B - Plan 505

The benefit programs listed below constitute the Benefits and Optional Benefit Programs covered by Plan 505 (in addition to the provisions of the Plan that establish the Flexible Benefits Program, the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account programs, as applicable). These programs are provided through fully-insured or unfunded arrangements.

A. VISION PROGRAM

Benefits under the Vision Program are provided through the following:

- United Healthcare Vision

B. LIFE INSURANCE PROGRAM

Benefits under the Life Insurance Program are provided through the following:

- Hartford Basic Life Insurance
- Hartford Supplemental Life Insurance

C. ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PROGRAM

Benefits under the Accidental Death & Dismemberment Program are provided through the following:

- Hartford Basic and Supplemental AD&D Insurance

D. SHORT-TERM DISABILITY PROGRAM

Benefits under the Short-Term Disability Program are provided through the following:

- Trinity Health STD Plan

E. LONG-TERM DISABILITY PROGRAM

Benefits under the Long-Term Disability Program are provided through the following:

- Hartford Basic LTD Insurance
- Hartford Voluntary LTD Insurance
- Unum Basic LTD Insurance
- Unum Voluntary LTD Insurance

F. HEALTH CARE FLEXIBLE SPENDING ACCOUNT

G. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

H. **SEVERANCE PROGRAM**

Benefits under the Severance Program are provided through the following:

- Trinity Health Corporation Severance Pay Plan

I. **GROUP PRE-PAID LEGAL SERVICES PROGRAM**

Benefits under the Life Insurance Program are provided through the following:

- Hyatt legal Plans, Inc.

J. **EMPLOYEE ASSISTANCE PROGRAM**

APPENDIX C - PARTICIPATING EMPLOYERS

1. Participating Employers that are Not Affiliated Employers

Sisters of Mercy Regional Community of Detroit, Inc.
Religious Sisters of Mercy
Sisters of the Holy Cross, Inc.
Holy Cross Sponsored Ministries
The Academy of the Holy Cross, Inc.
Covenant Medical Center, Inc. (part of Wheaton Franciscan – Iowa) – effective January 1, 2017
Sartori Memorial Hospital, Inc. (part of Wheaton Franciscan – Iowa) – effective January 1, 2017
Mercy Hospital of Franciscan Sisters, Inc. (part of Wheaton Franciscan – Iowa) – effective January 1, 2017
Saint Francis HealthCare Partners, Inc. – January 1, 2017 through December 31, 2017 only

2. Affiliated Employers that are Not Participating Employers

Saint Mary's Health System (Waterbury, CT) – will become a Participating Employer effective January 1, 2018

**FOURTH AMENDMENT
TO THE
TRINITY HEALTH CORPORATION WELFARE BENEFIT PLAN**

Background Information

- A. Trinity Health Corporation ("Trinity Health") previously adopted and maintains the Trinity Health Corporation Welfare Benefit Plan ("Plan") for the colleagues of Trinity Health and certain of its affiliates, and their eligible dependents and beneficiaries.
- B. Section 7.1 of the Plan authorizes the person appointed as Administrator, currently the Vice President, Total Rewards, to amend the Plan in accordance with the Materiality Thresholds and Authorization Limits set forth in the Trinity Health Corporation Table of Authority for Welfare Benefit Plans, as amended from time to time.
- C. In accordance with her delegated authority, the Administrator desires to amend Appendix C to the Plan to clarify the Participating Employers in the Plan, effective as of January 1, 2018.

Fourth Amendment to the Plan

The Plan is hereby amended as follows, effective as of January 1, 2018:

- 1. Appendix C is hereby replaced by the Appendix C attached hereto.
- 2. All other terms and provisions of the Plan shall remain unchanged.

TRINITY HEALTH CORPORATION

By: 
Jeahette Franck

Title: Vice President, Total Rewards

Date: 12-29-17

APPENDIX C - PARTICIPATING EMPLOYERS

1. Participating Employers that are Not Affiliated Employers

Sisters of Mercy Regional Community of Detroit, Inc.
Religious Sisters of Mercy
Sisters of the Holy Cross, Inc.
Holy Cross Sponsored Ministries
The Academy of the Holy Cross, Inc.
Covenant Medical Center, Inc. (part of Wheaton Franciscan – Iowa) – effective January 1, 2017
Sartori Memorial Hospital, Inc. (part of Wheaton Franciscan – Iowa) – effective January 1, 2017
Mercy Hospital of Franciscan Sisters, Inc. (part of Wheaton Franciscan – Iowa) – effective January 1, 2017
Burdett Care Center, Inc.

2. Affiliated Employers that are Not Participating Employers

Saint Agnes Medical Providers
