THE REINALT-THOMAS CORPORATION
D/B/A DISCOUNT TIRE / AMERICA'S TIRE / DISCOUNT TIRE DIRECT

FLEXIBLE BENEFITS PLAN

Restated Effective January 1, 2019

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INTRODUCTION

The purpose of the Plan is to allow you to choose among different types of Benefits, and pay your share of the cost of those Benefits on a tax-favored basis. You may choose Benefits based on your own particular goals, desires, and needs. These plans are often called "cafeteria plans" because they offer a "menu" of benefit choices. This Plan, as reflected on the following pages, is restated effective January 1, 2019.

Once you are eligible to participate in this Plan, you must do two things in order to begin your participation. First, you must tell us what Benefits you want. You can do this online in the HR Benefits system during open enrollment or if you have a family status change. (These, and other capitalized terms, are defined in Article VIII).

Second, you must agree to reduce your Compensation in an amount equal to the Benefits you want to receive under the Plan. You can do this online in the HR Benefits system. The Employer then converts each dollar (by which you agree to have your Compensation reduced) into a Flexible Benefits Plan Dollar, and contributes it to the appropriate account under the Plan, where it is used to provide your Benefits under the Plan.

Example: Here's an example that shows how you enroll under the Plan, and explains why participating in this Plan is a good idea. Assume you and your family are covered under your Employer's health care plan, and that you pay $200 per month for this coverage. Also assume that your monthly pay is $2,000, and that 25% ($500) goes to pay state and federal income taxes and Social Security taxes. You have $1,300 left after paying your health care premiums and taxes.

But now let's assume you enroll online in the plan indicating that you want to pay your health care premiums under this Plan. By signing up for the plan you agree to have your Employer reduce your Compensation in an amount equal to the premiums you owe. In this way, you don't pay tax on the amount by which your pay is reduced in order to pay your premium. Your $2,000 pay is reduced by $200 to pay your health care premiums, leaving you $1,800. You pay 25% tax on $1,800 instead of $2,000, so your tax bill is $450 instead of $500, leaving you with $1,350 and saving you $50 in taxes. However, see Article IX, wherein the Employer does not guarantee any particular tax result.

Here's an important point. If you agree to participate in this Plan, once you elect online in the HR Benefit system you can't change your benefit elections for the remainder of the coverage period, unless you meet certain requirements (these requirements are described in Article II).

ARTICLE I

BENEFITS AVAILABLE TO YOU

Benefit Options. You might recall from the Introduction that when your Employer reduces your Compensation, in accordance with your online election in the HR Benefits system, the Employer takes each dollar it withholds from your Compensation and converts it to a Flexible Benefits Plan Dollar. These Flexible Benefits Plan Dollars are then credited to various accounts under this Plan, and used to provide the Benefits you chose during your online election.

You may choose, during your online election to receive any or all of the following Benefits:

- Pre-Tax Health and Welfare Plan Premium Payment. You may choose to have Flexible Benefits Plan Dollars used to pay Premiums for coverage (on behalf of yourself, your Spouse and/or other Dependents, depending on whether they're eligible for the coverage) under the Employer's health and welfare benefit plan(s) listed below:
    - **Medical Plan.**
    - **Dental Plan.**
    - **Vision Plan.**
    - **Basic Life Plan.**
    - **Basic Accidental Death and Dismemberment (AD&D) Plan.**
    - **Voluntary Life Plan.**
    - **Short Term Disability Plan.**
    - **Long Term Disability Plan.**

    The rules concerning eligibility under, and the benefits available from, the plans listed above, are contained in the documents and contracts that comprise the plans.

- ***Health Care Reimbursement Program.*** You may elect coverage under the Health Care Reimbursement Program option. Appendix A describes the rules that apply to that Program.

- ***Dependent Care Reimbursement Program.*** You may elect coverage under the Dependent Care Reimbursement Program option. The rules that apply to that Program are set forth in Appendix B.

Nondiscrimination Requirements. The following paragraphs describe technical requirements of the Code that apply to plans like this Flexible Benefits Plan.

This Plan is intended to provide Benefits that do not discriminate in favor of Highly Compensated Individuals with respect to eligibility to participate, or Highly Compensated Participants, with respect to contributions and benefits. In addition, it is the intent of this Plan not to provide "qualified benefits" (as defined under Code Section 125(e)) to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan.

If the Administrator or its designee deems it necessary to avoid discrimination or possible taxation to Key Employees or Highly Compensated Individuals or Highly Compensated Participants, it may, but is not required to, reject any election or reduce contributions or nontaxable Benefits in order to assure that the rules in these paragraphs are not violated. Any act taken by the Administrator or its designee under these paragraphs will be carried out in a uniform and nondiscriminatory manner.

If the Administrator or its designee decides to reject any election or reduce contributions or nontaxable Benefits, it will be done in the following manner: the nontaxable Benefits of the affected Participant (either a Highly

Compensated Individual or Participant, or a Key Employee, whichever is applicable) who has elected the *highest amount* of nontaxable Benefits for the Coverage Period will have his or her nontaxable Benefits reduced until:

- the discrimination tests set forth in these paragraphs are satisfied, or
- the amount of his or her nontaxable Benefits equals the nontaxable Benefits of the affected Participant who has elected the *second highest* amount of nontaxable Benefits.

This process will continue until the nondiscrimination tests described in these paragraphs are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to these paragraphs, the reduction will first be made proportionately among noninsured Benefits, and once all noninsured Benefits are expended, proportionately among insured Benefits.

ARTICLE II

PARTICIPATION

Becoming Eligible to Participate, and Beginning Your Participation. If you were participating in the prior version of this Plan on the effective date of this restated Plan, you are automatically a Participant in this Plan as of the effective date. In other cases (for example, if you're a new Employee), you become eligible to participate in this Plan after 90 days of continuous full-time service. Although you might be eligible to participate in the Plan, you must actually make an online election in the HR Benefits system in order to actually begin your participation, and obtain the benefits of the Plan. As noted earlier, as a general rule, the online elections in the HR Benefits system you make cannot be changed until the end of the Coverage Period for which you make them, unless you are permitted to change them under the special rules described in Article III.

Terminating Your Participation. Your participation in the Plan will end when one of the events described elsewhere in this Plan you and/or your Dependent might be eligible to continue your participation, at least for a while). The events are:

- Termination of your employment.
- The date you cease to be an Eligible Employee.
- Your death.
- The termination of this Plan itself.
- The date you validly revoke your online election in the HR Benefits system.

Special Rules Concerning Termination of Employment. If your employment terminates (for any reason other than your death), you may continue to file claims for reimbursement under the Health Care Reimbursement Program and/or Dependent Care Reimbursement Program, but only for expenses incurred through your termination date. Whether or not your (and your Dependents') coverage under the Employer's benefit plans terminates at the same time depends on the terms of those plans.

COBRA Coverage. If you or one of your covered Dependents lose coverage under one or more of the Employer's health care plans (including dental and vision plans) under circumstances where you or the Dependent are entitled to continue coverage under the federal law known as COBRA[1], and you or the Dependent would also lose coverage under the Health Care Reimbursement Program due to those same circumstances, you or the Dependent also have a right under COBRA to continue coverage for a short time while under the Health Care Reimbursement Program. In this way, you or the Dependent may be able to obtain reimbursement for claims Incurred *after* coverage would otherwise have ended but for the continued coverage under COBRA. See the Health Care Reimbursement Program Appendix for more information.

USERRA Coverage. If you lose coverage under one or more of the Employer's health care plans (including dental and vision plans) or the Health Care Reimbursement Program because you commence a period of uniformed service to which the Uniformed Services Employment and Reemployment Rights Act applies, you may continue your coverage and, notwithstanding any other provision in this Plan to the contrary, your participation in this Plan (to the extent you have wages from the Employer) for the duration of your period of uniformed service or 24 months, whichever period is shorter. See the Health Care Reimbursement Program Appendix for more information.

[1] This right to continue coverage applies, for example, where your coverage ends due to termination of your employment (for reasons other than gross misconduct) or reduction in work hours, or your death. Your covered family members might have the right to continue coverage where their coverage ends due to termination of your employment (for reasons other than gross misconduct) or reduction in work hours; your death; your divorce or legal separation; your entitlement to Medicare; or a covered child's ceasing to meet the definition of an eligible child under the plan. These events are known as "qualifying events" because they "qualify" you or the family member for COBRA coverage.

Special Rules Concerning Reemployments. If you participate in the Plan during a Coverage Period, then terminate employment but are rehired during that same Coverage Period, you may be able to make a benefit change in the online HR Benefits system for the remaining portion of the Coverage Period. You may do so if the termination of employment and the reemployment are *bona fide*. The termination and reemployment are deemed to be *bona fide* if you come back with in a year, if you were previously enrolled and are hired back within a year you can re-elect benefits with no waiting period. See also the special rules described in Article III, in the section titled, *Mid-Year Changes to Elections*.

Special Rules Concerning Leave of Absence. An employee who (1) is on an approved leave of absence under the Family and Medical Leave Act ("FMLA")f as described in Article III or (2) is receiving short term disability pay under the Company's Short Term Disability Plan, will remain eligible under the plan in the same manner as an active employee, provided that the employee continues to timely make timely required employee contributions pursuant to the Company's policies. An employee on an approved medical leave of absence remains eligible in the same manner as an active employee for up to an additional 18 months following the exhaustion of FMLA or Short Term Disability Benefits (whichever occurs later) provided that (1) employment has not been terminated earlier in accordance with the Company's employment policies and (2) the employee continues to timely make required employee contributions pursuant to the Company's policies. An employee on an approved leave of absence other than for medical leave remains eligible for up to an additional 18 months provided that (1) employment has not been terminated earlier in accordance with the Company's employment policies and (2) the employee continues to timely make required employee contributions pursuant to the Company's policies. This additional 18-month period begins on the later of (1) the first day of the leave of absence or (2) the first day of the leave following the period subject to FMLA has been exhausted. An employee will be offered continued coverage under COBRA as of the date the employee loses eligibility for coverage unless coverage ceases due to nonpayment of employee contributions. Notwithstanding, an employee who fails to pay employee contributions during FMLA will be offered COBRA for coverage beginning as of the first day following the last day of FMLA leave even if the employee fails to pay employee contributions during FMLA leave (coverage will cease during any period of nonpayment but may be reinstated prospectively by electing COBRA at the end of FMLA).

Special Rules Concerning Death. If you die your participation in the Plan will cease. Your beneficiaries or the representative of your estate, however, may submit claims for expenses that you incurred through the date of your death. You may designate a specific beneficiary for this purpose. If no beneficiary is specified, the Administrator or its designee may designate your Spouse, one of your other Dependents, or a representative of your estate. Claims Incurred by your Spouse or other of your covered Dependents through the date of your death may also be submitted for reimbursement.

Under the COBRA rules discussed above, your Spouse and Dependents may be able to continue to participate under the Health Care Reimbursement Program through the end of the Coverage Period in which you die. Your Spouse and Dependents may be required to make contributions in order to continue their participation.

ARTICLE III

BENEFIT ELECTIONS

Initial Benefit Elections. Once you meet the eligibility requirements described in Article II you can choose to participate in this Plan for the remainder of the Coverage Period, but to do so you must make a benefit election in the online HR Benefits system within **30 days** after you first become eligible.

Your initial Benefit Election will apply to expenses that are reimbursable or payable by this Plan and that are incurred *after* the Administrator or its designee receives your benefit elections. As a general rule, the benefit elections will continue in effect for the remainder of the Coverage Period.

For example, assume that you first become eligible to participate in this Plan on March 1 of a given Coverage Period. Your initial Election Period will run from that March 1 to March 30. Your benefit election must be filed with the Administrator or its designee in the online HR Benefits system within this period, in order for you to receive any benefits under this Plan for the remainder of that Coverage Period. If you fail to enroll in your benefit elections on time you must wait until the annual Election Period (described below) to make a new election in the online HR Benefits system.

Subsequent Annual Elections. During the annual Election Period (defined in Article VIII), you may choose, via online election in the HR Benefits system, a benefit election that you wish to purchase for the next Coverage Period. Any election you make must be completed before the end of the annual Election Period and will apply for the following Coverage Period. For example, assume that the annual Election Period is the month of October. If you make an online election in the HR Benefits system during the month of October of a given year ("Year 1"), for the ensuing Coverage Period (beginning, say, January 1 of the following year ("Year 2"), the election will apply to the Coverage Period beginning that January 1.

Choosing to Participate After Initially Declining to Participate. In addition, if you fail to file your initial election in the online HR benefits system on time (or simply chose not to file it) you can choose during an ensuing annual Election Period to participate in the Plan with online elections in the HR Benefits system, effective for the ensuing Coverage Period. Of course, in order to be able to do this you must still be eligible to participate in the Plan.

Terminating Participation in the Plan. If you want to terminate your participation in the Plan, you can do that by waiving coverage in the online HR Benefits system during the annual Election Period.

If during the Annual Election Period you choose not to participate for the next Coverage Period you will have to wait until the next annual Election Period before you will again have an opportunity to participate in the Plan. However, you might be permitted to make an online election in the HR Benefits system earlier than the next annual Election Period if you meet the requirements for changing Benefit Elections described below, in the section titled, *"Mid-Year Changes to Elections."*

Failure to Make a New Election. If you're participating in the Plan but fail to make online elections in the HR Benefits system during the annual Election Period, what happens then depends on the Benefits you were receiving under the Plan.

With regard to coverage for which you must pay *Premiums* (such as coverage under a health care plan) if you fail to make online changes in the HR Benefits you will be *deemed* to have made, for the ensuing Coverage Period, the *same* Benefit Elections that are then in effect for the current Coverage Period. You will also be deemed to have elected to have your Compensation reduced for the next Coverage Period in an amount necessary to purchase those Benefits.

With regard to Benefits for which you pay no Premiums but *do* make contributions (such as the Health Care or Dependent Care Reimbursement Programs), you will be deemed to have elected *not* to receive any of those Benefits for the upcoming Coverage Period. No further reductions from your Compensation will be made for the next Coverage Period in order to provide such Benefits to you. As a result, with respect to the Health Care and

Dependent Care Reimbursement Programs, filing *no election* is the same as choosing not to participate for the next Coverage Period.

Example: Assume that the Plan's annual Election Period is the month of October. Assume also that in October of a given year ("Year 1") you choose to have your Compensation in the following year ("Year 2") reduced in an amount sufficient to pay for coverage under the Employer's group health care plan. You also choose to have your Compensation reduced by $100 per month and to have that amount contributed to the Health Care Reimbursement Program or Dependent Care Reimbursement Program (the $100 per month allows you to receive up to $1,200 in Benefits from the Program for the Coverage Period).

If during the annual Election Period in October of Year 2 you make no election for the following year ("Year 3"), then for Year 3 you will be deemed to have elected to:

- contribute *nothing* to the Health Care Reimbursement Program (or Dependent Care Reimbursement Program, as the case may be) for Year 3 (meaning you'll be entitled to no Benefits under that Program for that Coverage Period), ***but***
- *continue* to have your Compensation reduced in Year 3 in an amount sufficient to pay your Premiums due under the Employer's group health care plan.

Mid-Year Changes to Elections. As a general rule the Code does not allow you to change online elections in the HR Benefits system after the start of a Coverage Period and make a new Benefit Election for the remainder of the Coverage Period. However, there are exceptions to this rule. The exceptions are described below, and the exception that applies to you depends on the Benefits that will be affected by your change. *If an exception applies to you, the change in the online HR benefits system must be made (received by the Plan Administrator) within **30 days** after the date of the event that gives rise to your right to make the change.* However, in some situations as described below, you may have up to 60 days to make your change.

These rules are complex; if you have questions about them, contact your Human Resources Benefits Representative. In addition, please note that notwithstanding anything in this Article to the contrary, the terms of the benefit plan or program under which you are purchasing coverage under this Plan may prohibit a mid-year change to your online elections in the HR Benefits system and in that case the terms of the benefit plan or program shall control over the terms of this Plan.

In this section, the term "mid-year" means "mid-Coverage Period."

Events Entitling You to Change Elections Concerning Payment of <u>Health Insurance Premiums</u>. For purposes of this section, the term "health insurance" includes medical, dental, and vision insurance, whether insured or self-insured by the Employer.

- **HIPAA Special Enrollment.** You may cancel your online elections in the HR Benefits system for the remainder of the Coverage Period with respect to coverage under a group health care plan where the cancellation of the old, and the making of the new elections correspond with a "special enrollment" right under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). ***If the "special enrollment event" is the birth, adoption or placement for adoption of an eligible child, and the health plan allows you to enroll the child retroactively (to the date of birth, adoption or placement for adoption), your election change may also be given retroactive effect.***

- Please note that notwithstanding the general rule that you must request the enrollment change within 30 days after the event giving rise to the special enrollment right, if you or your Dependent become eligible for a state-granted premium subsidy for the Employer's health coverage, you may request enrollment under the Employer's health coverage within ***60 days*** after the date Medicaid or the Children's Health Insurance Program (CHIP) determine that you or the Dependent qualify for the subsidy. Similarly, if you or your Dependent loses coverage under Medicaid or CHIP, you may request enrollment under the Employer's health coverage, again within ***60 days*** of the date you or the Dependent lose such coverage.

- **Court Decree.** You may cancel your online elections in the HR Benefits system for the remainder of the Coverage Period where a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody requires either you or your Spouse, former Spouse or other individual to provide health insurance coverage for your Dependent child. You may add coverage for the child if the court order requires you or the Employer's health care plan(s) to provide coverage for the child. You may drop coverage for the child if the court order requires your Spouse, former Spouse or other individual (or their employer's health care plan(s)) to provide coverage for the child, and your Spouse, former Spouse or other individual actually acquires coverage for the child. The Plan may make a unilateral change to your online election in the HR Benefits system under these circumstances, to provide for coverage of your Dependent child under the Employer's health care plan(s), where the order is a qualified medical child support order and the order requires the plan(s) to provide coverage.

- **Entitlement to Medicare or Medicaid.** You may cancel your online elections in the HR Benefits system for the remainder of the Coverage Period where you, your Spouse, or other Dependent becomes entitled to, or ceases to be entitled to, benefits under either Medicare or Medicaid. Where the individual becomes entitled to Medicare or Medicaid benefits you may modify your online election in the HR Benefits system to drop coverage of the individual under your Employer's health care plan(s). Similarly, where the individual ceases to be entitled to Medicare or Medicaid benefits you may modify your online election in the HR Benefits to add coverage of the individual under your Employer's health care plan(s).

- **Changes in Status.** You may cancel your online elections in the HR Benefits system for the remainder of the Coverage Period where you experience a **"change in status"** and the change to your online elections in the HR Benefits system is **"consistent with"** that change in status. A "change in status" is:

    - A change in your legal marital status, including your marriage, the death of your Spouse, the annulment of your marriage, or your divorce or legal separation;

    - A change in the number of your Dependents, including the birth, adoption, placement for adoption, or death of a Dependent;

    - A change in the employment status of you, your Spouse or other Dependent; a "change in employment status" includes:

        - Termination or commencement of employment (if commencement of employment follows a termination of employment with the same employer, no new election is permitted unless the commencement follows at least 30 days after the termination);

        - Commencement of, or the return from, an unpaid leave of absence;

        - Change in work site;

        - Satisfying, or ceasing to satisfy, eligibility conditions due to a change in employment status (a switch between part-time and full-time employment, salaried and hourly positions, etc.);

    - An event that causes your Dependent to satisfy or cease to satisfy the eligibility requirements for coverage whether due to the attainment of a specified age, student status, or any similar circumstance described in such plan(s); or

    - A change in the place of residence or employment of you, your Spouse, or your other Dependent.

  Your change in your online elections in the HR Benefits is "consistent with" a change in status if and only if the change in status **affects eligibility for coverage** under an employer's plan, ***and*** the election change is **on account of and corresponds with** the change in status.

  A change in status that affects eligibility for coverage includes a change in status that causes an increase or

decrease in the number of your family members who may benefit from coverage under the plan. For example, let's say you wish to change your election to drop coverage under this Plan for you or your Spouse because, due to a marital status change or a change in your Spouse's employment status, you or your Spouse now qualify for coverage under a plan provided by your Spouse's employer. You can make the election change so long as the person you wish to disenroll under this Plan acquires the newly available coverage under your Spouse's plan. We will allow the election change upon your certification that coverage has been or will be obtained under the other plan.

Notwithstanding this consistency rule, if you, your Spouse or other Dependent become eligible (under a health care plan maintained by the Employer) for COBRA continuation coverage or continuation coverage under any similar state health coverage continuation law, you may contact the Company's COBRA Administrator in order to elect and pay for that continuation coverage.

- Family and Medical Leave. You may cancel your online elections in the HR Benefits system for the remainder of the Coverage Period if you take a leave of absence pursuant to the Family and Medical Leave Act ("FMLA"). In addition,

    - If you continue your participation during the period of FMLA leave, you will be entitled to change your online elections in accordance with the rules described above, to the same extent as any other Participant who is not on FMLA leave;

    - If you continue your participation during the period of FMLA leave the Employer may permit you, under procedures applied in a nondiscriminatory manner, to pay your share of the cost of coverage under one or more of the following methods (note, however, that where the period of FMLA leave is substituted paid leave, your method of paying your required contributions must be the same method normally used by Participants during paid leave):

        - ***Pre-pay option.*** You may, prior to beginning your FMLA leave, pre-pay on a pre-tax basis (from taxable Compensation payable to you, including the cashing out of unused sick days or vacation days) the contributions required on your behalf for the period of FMLA leave. But if the period of FMLA leave begins in one Coverage Period and ends in another Coverage Period, you may not pre-pay, on a pre-tax basis, for coverage during the period of FMLA leave that extends into the next Coverage Period. The cost of coverage for periods of FMLA leave in the next Coverage Period must be paid under the method described below.

        - ***Pay-as-you-go option.*** You may pay (on a pre-tax basis, from taxable Compensation otherwise payable to you, or on an after-tax basis) the contributions required on your behalf for the period of FMLA leave on the same schedule under which payments would be made if you were not on FMLA leave. For example, if while not on FMLA leave your contributions to the Plan were made bi-weekly, you may make your contributions bi-weekly while on FMLA leave. Alternatively, you may pay the required contributions on the same payment schedule that applies to payment for COBRA continuation coverage under the Employer's group health care plan or dental plan (i.e., typically monthly, with a 30-day grace period for each monthly payment).

        - ***Catch-up option.*** To the extent you and the Employer agree in advance, the Employer may continue your coverage(s) during a period of unpaid FMLA leave, and that you will not pay your share of the premiums until you return from leave. You and the Employer must agree in advance of the period of continued coverage that: (i) you elect to continue your coverage while on unpaid leave; (ii) the Employer assumes responsibility for advancing premium payments on your behalf during the FMLA leave; and (iii) these advance amounts are repaid by you after your return from FMLA leave. However, the Employer has the option of using this "catch up" feature unilaterally, where you intend but fail to make premium payments while on leave (that is, you utilize the pay-as-you-go option but fail to make premium payments). In that case, the Employer may unilaterally

pay your share of the premium while you're on FMLA leave, and then recoup its advance from you after your return. No advance agreement is required in this latter case.

Upon your return from FMLA leave, your "catch-up" contributions may be made on a pre-tax basis from any taxable compensation to which you're entitled (including unused sick leave and vacation days). Premiums may also be paid from salary reductions on a pre-tax basis if the premiums were not paid under any other method while you were on leave. You may also make "catch-up" contributions on an after- tax basis.

- If your coverage under the Plan terminated while you were on FMLA leave (either because you cancelled Premiums or other contributions), you may recommence participation after you return from FMLA leave. You do that by making an online election in the HR Benefits system within 30 days of your return.

- ***Significant Changes in the Cost of Coverage.*** If the cost of a benefit requiring contributions from you increases or decreases during the year, your benefit election will change automatically to keep pace with the change in required contributions. See the discussion about this automatic change, in Section IV.

  You may cancel your benefit elections during a Coverage Period there is a significant increase *or* significant decrease in the cost of a benefit package option under the Employer's plan(s). (A "benefit package option" is a qualified benefit under Section 125(f) of the Code or an option for coverage under an underlying health care plan, such as a PPO, or HSA option.) In that case you may then make a new benefit election to either (i) receive coverage under the option with the decrease in cost, (ii) revoke coverage under the option with an increase in cost and elect similar coverage under another benefit package option providing similar coverage or, if there is no other option with similar coverage available, drop coverage entirely. No automatic adjustment in your benefit elections, as described in Article IV, will be made under these circumstances.

  For purposes of this rule, a "cost increase" or "cost decrease" refers to an increase or decrease in the amount of contributions you make under this Plan, whether due to actions taken by you (switching between part-time and full-time employment, etc.) or from an action by your Employer (such as decreasing the cost of coverage for a classification of employees of which you're a member).

- **Significant Changes in Coverage.** You may cancel your online elections in the HR Benefits system where during a Coverage Period your, your Spouse's or other Dependent's coverage under a plan of the Employer is significantly curtailed or ceases. Coverage is considered significantly "curtailed" if, among other things, there is a significant increase in the deductible, the copay, or out-of-pocket maximum amount under a health plan. In that event, you must then make a new benefit election in the HR Benefits system to elect coverage on a prospective basis for such person under another benefit package option providing similar coverage. Coverage under a plan is significantly curtailed only if there is an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to participants generally.

  If there is a "loss" of coverage, you may elect coverage on a prospective basis for such person under another benefit package option providing similar coverage, or drop coverage if there is no other option providing similar coverage. A "loss" of coverage includes a complete loss of coverage (including the elimination of a benefit package option ceasing to be available in the area where the person resides, the individual's attainment of an overall annual maximum under a plan, a substantial decrease in the number of medical providers available under the option (such as a major hospital ceasing to be a member of a managed care network, or a substantial decrease in the number of physicians participating in the network), a reduction in the benefits for a specific type of medical condition or treatment (where you, your Spouse or other Dependent is currently in a course of such treatment), or any other similar fundamental loss of coverage.

- **Addition (or Improvement) of Benefit Package Option.** You may cancel your online elections in the HR Benefits system where during a Coverage Period a plan of the Employer adds a new benefit package option or other coverage option (or significantly improves an existing benefit package option or other coverage

option). In that case you may then make a new benefit election in the online HR Benefits system to elect the newly-added or improved option prospectively.

- **Loss of Coverage Under Certain Governmental or Educational Institution Plans.** You may cancel your online elections in the HR Benefits system where during a Coverage Period you, your Spouse or other Dependent lose coverage under any group health plan sponsored by a governmental or educational institution, including a State children's health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government, the Indian Health Service or a tribal organization; a State health benefits pool; or a foreign government group health plan. You may then make a new election in the online HR Benefits system to provide coverage for such person on a prospective basis under a plan of the Employer.

- **Change in Coverage Under Other Plan.** You may cancel your elections in the online HR Benefits system for the remainder of the Coverage Period, where the change is on account of and corresponds with a change made under another plan maintained by your Employer or another employer if:

    - That other plan permits participants to make an election change that would be permitted under the rules of this Article (disregarding this section concerning changes in coverage under another plan); or
    - This Plan permits you to make an election for a period of coverage that is different from the period of coverage under the other plan.

Events Entitling You to Change Elections Concerning Contributions to the Health Care Reimbursement Program. The events and requirements under which you may make a mid-year change to your elections in the online HR Benefits system for Flexible Spending Accounts with respect to contributions to the Health Care Reimbursement Program are the same events and requirements described above (with respect to payment of health insurance premiums), ***with the following exceptions:***

- The events described in the heading titled, **HIPAA Special Enrollment Events** are applicable only if the Health Care Reimbursement Program is subject to HIPAA. In most cases a health care reimbursement program is not subject to HIPAA. Ask the Administrator.

- The events described in the headings titled, **Significant Changes in the Cost of Coverage, Significant Changes in Coverage, Addition (or Improvement) of Benefit Package Option, Loss of Coverage Under Certain Governmental or Educational Institution Plans,** and **Change in Coverage Under Other Plan** do not authorize changes to online elections in the HR Benefits system concerning the Health Care Reimbursement Program.

Note also that if you change your online elections in the HR Benefits system as to the Health Care Reimbursement Program, you may not *reduce* the amount you elect to contribute to the Program for the Coverage Period below a certain amount. That amount is equal to the amount of Benefits paid to you by the Program during the Coverage Period and prior to the event justifying your change in Benefit Election.

In addition, and notwithstanding any other provision in this Plan to the contrary (except the provisions concerning contributions and coverage during a period of FMLA leave), if after making an online election in the HR Benefits concerning the Health Care Reimbursement Program, there is insufficient Compensation for the Employer to make salary reductions in the amount elected on your online elections in the HR Benefits system the Employer may treat you as ineligible to continue your participation in the Program due to nonpayment of premiums, and may permit you to cancel your election and make a new election for no coverage under the Health Care Reimbursement Program. Alternatively, the Employer may unilaterally cancel your participation in the Program due to nonpayment of premium. However, otherwise covered claims incurred prior to the termination of your participation, and timely submitted for reimbursement, will still be considered for payment notwithstanding the subsequent termination of coverage.

Events Entitling You to Change Elections Concerning Contributions to the Dependent Care Reimbursement Program. The events and requirements under which you may make a mid-year change to your online elections in

the HR Benefits system with respect to contributions to the Dependent Care Reimbursement Program are the same events and requirements described above (with respect to payment of health insurance premiums), with the following exceptions:

- The events described in the headings titled, **HIPAA Special Enrollment Events, Court Decree, Family and Medical Leave, Loss of Coverage Under Certain Governmental or Educational Institution Plans,** and **Entitlement to Medicare or Medicaid** do not apply.

- The **Change in Status** rules described above (with respect to payment of health insurance premiums) apply; in order for an election change to be considered "consistent with" the change in status, the election change must affect eligibility for coverage under an employer's plan, ***and*** the election change must be on account of and correspond with the change in status. An election change meets this consistency requirement if the election change is on account of and corresponds with a change in status that affects Employment-Related Dependent Care Expenses described in Appendix B. For purposes of the "change in status" rules as they apply to the Dependent Care Reimbursement Program, the term "Dependent" means your Qualifying Dependent as described in the appropriate Appendix B. Thus, for example, a "change in status" occurs when your Dependent child attains age 13 and is therefore no longer a "Dependent" for purposes of the Dependent Care Reimbursement Program.

- The events described in the headings titled, **Significant Changes in the Cost of Coverage, Significant Changes in Coverage, Addition (or Improvement) of Benefit Package Option,** and **Change in Coverage Under Other Plan** apply; however:
    - The term "Dependent" means your Qualifying Dependent as described in the appropriate Appendix; and
    - The rules concerning Changes in Cost of Coverage apply only if the cost change is imposed by a dependent care provider who is not your relative. For this purpose, a "relative" is a child (including a stepchild) or grandchild, a brother or sister (or stepbrother or stepsister), parent (including a stepparent), grandparent or great- grandparent, a niece or nephew, uncle or aunt, or mother- or father-in-law, brother- or sister-in-law, or son- or daughter-in-law. A child includes a foster child and a child adopted by or placed for adoption with you. A sister or brother includes a sister or brother by half blood.

In addition to the rules described above, you may make changes to your online elections in the HR Benefits system to the extent consistent with the requirements of the Uniformed Services Employment and Reemployment Rights Act, when you commence or return from a period of uniformed service under circumstances protected by the provisions of that Act.

ARTICLE IV

YOUR CONTRIBUTIONS TO THE PLAN

Salary Reduction Agreements – General Rules. Recall that, to participate in this Flexible Benefits Plan, you must both choose the Benefits you want to receive online in the HR Benefits system. Your Benefits under the Plan are financed by reductions from your Compensation, as authorized by your online elections in the HR Benefits system, that is, the amount by which your Compensation is reduced must be sufficient to pay for the Benefits you chose. These elections may be made on the same form, to be provided by the Employer.

Your Employer will administer its payroll program to allow you to agree, under the online elections in the HR Benefits system, to reduce your Compensation during a Coverage Period by the amount necessary to purchase the Benefits you choose (note, however, that the Code might impose limits on your selections). You indicate through your online elections in the HR Benefits system how much you will contribute under the Plan for the year. The online elections in the HR Benefits system will apply for the entire Coverage Period and can't be changed except as provided under the special rules in Article III concerning *Mid-Year Changes to Elections*.

As a general rule, the amounts you agree to contribute to the Plan will be contributed on a *pro rata* basis for each pay period during the Coverage Period (that is, the same amount will be subtracted from your Compensation each pay period). However, the Employer may also allow you to make your contributions to the Plan in advance (for example, in a single sum at the beginning of the Coverage Period). Each dollar contributed to the Plan under your online elections in the HR Benefits system will be "converted" into what the Plan calls a "Flexible Benefits Plan Dollar" and allocated to the appropriate funds or accounts under the Plan, to pay for the Benefits you chose in the online HR Benefits system.

Initial elections in the online HR Benefits system will apply to pay periods that end during the Coverage Period to which the initial Agreement applies. For example, if you first become eligible to participate effective March 1 of a given year, that Agreement generally will apply for the remainder of the Coverage Period that includes that March 1.

Subsequent online elections in the HR Benefits system can be made during the annual Election Periods that occur shortly before each new Coverage Period. You'll make these new Agreements at the same time that you make your new Benefit Elections for the ensuing Coverage Period, as described in Article III. There are special rules in Article III that describe what happens if you don't make online election in the HR Benefits system during the annual Election Period. These same rules would apply here.

Changing Your Online Elections in the HR Benefits System. Generally, you may not change your online elections in the HR Benefits system during the Coverage Period. However, there are two exceptions to this rule:

- ***First,*** you may cancel, or change your benefit elections online in the HR Benefits system during a Coverage Period if the circumstances under which you intend to cancel, change or make your Agreement meet the requirements described in Article III in the section there titled, *Mid-Year Changes to Elections*.

- ***Second,*** your online elections in the HR Benefits system will automatically change to the extent necessary to conform to any increase or decrease in the cost of coverage of any of the Employer's health and welfare plans under which you are enrolled.

For example, assume that you choose coverage under the Employer's group health care plan, and choose to have your cost of coverage paid under this Plan. Assume your monthly cost of coverage under the health care plan, at the beginning of the year, is $100.

If your cost of coverage increases or decreases during the course of the year, then as a general rule your Salary Reduction Agreement will automatically change to correspond to the adjusted Premium amount. The rules in Article III concerning mid-year changes to Benefit Elections describe situations where, due to a change in the cost of some coverages, you might be entitled to cancel your online elections in the HR Benefits system.

What Your Employer Does with the Reductions from Your Compensation. As soon as practicable after each pay period your Employer will take the amount by which you agreed, in your online elections in the HR Benefits system to have your Compensation reduced and convert those dollars into Flexible Benefits Plan Dollars. It will then apply those Flexible Benefits Plan Dollars to provide the Benefits you chose online in the HR Benefits system.

ARTICLE V

CLAIMS AND APPEALS

Claims and Appeals for Fully-Insured Benefits. For fully-insured benefits, the applicable insurance company will serve as the Claims Administrator. In this role, the insurer will determine the amount of, and entitlement to, benefits of the component benefit programs provided under insurance contracts. The Claims Administrator has the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract. To obtain benefits from the insurer of a component benefit program, you must follow that insurer's claims procedures.

The insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. The insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. If you do not appeal on time, you may lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain component benefit programs you may also have the right to obtain external review (that is, review outside of the Plan).

Claims and Appeals for Self-Funded Benefit. For purposes of determining the amount of, and entitlement to, benefits under the self-funded component benefit programs provided through your Employer's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must submit a claim to the Claims Administrator in accordance with the claims procedure for that component benefit program. The Claims Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim.

The Claims Administrator will decide your claim in accordance with the claims procedures for the applicable component benefit program. For component benefit programs subject to ERISA, the claims procedures will be reasonable and will comply with applicable ERISA requirements. If the Claims Administrator denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal that decision and seek further review of the denied claim. The Claims Administrator will decide your appeal in accordance with reasonable claims procedures, as required by ERISA (if ERISA applies). If you do not appeal on time, you may lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

See the Attachments for information about how to appeal a denied claim under a self-insured component benefit, and for details regarding the Plan's appeals procedures.

***Claims Deadline*.** Unless specifically provided otherwise in a component benefit program or pursuant to applicable law, an initial claim for benefits under this Plan must be made within twelve months of the date the expense was incurred that gives rise to the claim.

It is the responsibility of the employee or covered family member, or his or her designee, to make sure this requirement is met.

***Mandatory Arbitration*.** In addition to the claims procedures stated above (and as listed in your component benefit programs), you must submit to non-binding arbitration for any dispute arising out of or relating to the Plan prior to

bringing a lawsuit in court (note, that the arbitration will be final and binding if agreed to in advance by both parties). All arbitrations will be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association, and will proceed solely on an individual basis. You do not have the right to arbitrate any dispute in a representative capacity or on a class action basis. Any dispute as to arbitrability shall be determined by the arbitrator.

Limitations Period for Filing Suit

Unless specifically provided otherwise under a component benefit program or pursuant to applicable law, a suit for benefits under this Plan must be brought within six months after the date of a final decision on the claim in accordance with the applicable claims procedures.

See the following paragraphs below, and Appendix A, for rules concerning claims under the Health Care Reimbursement Program. See the following paragraphs below, and Appendix B describing the Dependent Care Reimbursement Program, for rules concerning claims under that Program.

Review of Health Care Reimbursement Claims. The Claims Administrator will review and decide a claim (appropriately filed with it) for reimbursement under the Health Care Reimbursement Program within 30 days after receipt of the claim. The Claims Administrator may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Claims Administrator will notify the claimant within the initial 30 day timeframe of the reason for the extension and the date by which the Plan expects to render its decision.

If the Plan cannot render a decision within 30 days because the claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension will describe the specific information needed to complete the claim. The claimant will have at least 45 days from receipt of the notice to provide the required information. The Plan will then have 15 days from the date of receiving the claimant's information to render its decision. The claimant may agree to extend these deadlines.

Form and Content of Notice of Adverse Determination on Health Care Reimbursement Claims. If a claim is denied in whole or in part, notice of such adverse determination will be provided to the claimant. Notice will be written or electronic. The notice will include the following:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the determination is based;
- If applicable, a description of any additional information needed for the claimant to perfect the claim and an explanation of why such information is needed;
- A description of the Plan's review procedures, including the claimant's right to bring a civil action under Section 502(a) of ERISA;
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;
- If the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant's medical circumstances, or a statement that this will be provided without charge upon request; and
- In the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims.

Right to Appeal Decision on Health Care Reimbursement Claims. Any claimant who has had a claim for benefits denied in whole or in part by the Claims Administrator, or is otherwise adversely affected by action of the Claims Administrator, has the right to request review by the Administrator. Such request must be in writing, and must be made within 180 days after the claimant is advised of the Claim Administrator's action. If written request for review is not made within such 180-day period, the claimant will forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all pertinent documents and submit issues and comments in writing. The Administrator or its designee may prescribe a reasonable procedure under which a claimant may designate an authorized representative.

Action on Appeal of Health Care Reimbursement Claim. The Administrator or its designee will then review the claim. The person or entity that reviews the claim will be a fiduciary under the Plan, and will not be the same person, or a person subordinate to the person, who initially decided the claim. If the adverse benefit determination was based on medical judgment, the person handling the appeal will consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved, and such professional will not be the same professional who was consulted with respect to the initial action on the claim.

The person or entity deciding the appeal may hold a hearing if it deems it necessary and shall issue a written or electronically disseminated decision reaffirming, modifying or setting aside the initial decision on the claim. The decision on appeal will be made within 60 days; the time period begins to run on the date the appeal is received by the Plan or its designee. The claimant may agree to further extend these deadlines.

A copy of the decision will be furnished to the claimant. The decision shall set forth:

- The specific reason or reasons for the adverse determination;
- Reference to the specific plan provisions on which the determination is based;
- a statement that the claimant is entitled to receive without charge reasonable access to any document: (1) relied on in making the determination; (2) submitted, considered or generated in the course of making the benefit determination; (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination; or (4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
- A statement of any voluntary appeals procedures and the claimant's right to receive information about the procedures as well as the claimant's right to bring a civil action under Section 502(a) of ERISA;
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request; and
- If the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the claimant's medical circumstances, or a statement that this will be provided without charge upon request.

The decision will be final and binding upon the claimant and all other persons involved.

Review of Dependent Care Reimbursement Claims. The Claims Administrator will review and decide a claim (appropriately filed with it) for reimbursement under the Dependent Care Reimbursement Program within 90 days after it is timely filed. If the Claims Administrator denies a claim, the Claims Administrator will provide notice to you or your beneficiary, in writing, within 90 days after the claim is filed, unless special circumstances require an extension of time for processing the claim. No extension will be for more than 90 days after the end of the initial 90-day period.

If an extension of time for processing is required, written notice of the extension will be furnished to you or your beneficiary before the end of the initial 90-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which a final decision will be rendered. You will be informed in writing of the time limits set forth in this paragraph. If the Claims Administrator does not notify you of the denial of the claim within the period specified above, then the claim will be deemed denied.

Form and Content of Notice of Adverse Determination on Dependent Care Reimbursement Claims. If a claim appropriately filed with the Claim Administrator is wholly or partially denied, you or your beneficiary will be furnished a written notice setting forth in a manner calculated to be understood:

- The specific reason or reasons for the denial;
- Specific references to the pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you or your beneficiary to perfect the claim and an explanation as to why such information is necessary; and
- An explanation of the Plan's claim procedure, including the steps to be taken if you or your beneficiary wishes to appeal the claim, the period within which the appeal must be filed, and the period within which it

will be decided.

Right to Appeal Decision on Dependent Care Reimbursement Claim. Within 60 days after receipt of the above material, you or your beneficiary will have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. You or your beneficiary or your (or the beneficiary's) duly authorized representative may:

- Request a review upon written notice to the Administrator;
- Review pertinent documents; and
- Submit issues and comments in writing.

Action on Appeal of Dependent Care Reimbursement Claim. A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing). In that case a decision will be rendered as soon as possible, but not later than 120 days after receipt. If such an extension of time for deciding the appeal is required, written notice of the extension will be furnished to you or your beneficiary prior to the commencement of the extension. The decision of the Administrator will be written and will include specific reasons for the decision, written in a manner calculated to be understood by you or your beneficiary, with specific references to the pertinent Plan provisions on which the decision is based.

The Status of Your Plan Accounts Pending Appeal. Any balance remaining in a Reimbursement Account described in one or more Appendices (as applicable) at of the end of a Coverage Period will be forfeited and credited to the Employer's Benefit Plan Surplus as described in the appropriate Appendices, as applicable. However, if you had made a claim for such Coverage Period, in writing, which was denied or is pending, the amount of the claim will be held in your Account until the claim appeal procedures described above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Coverage Period will be forfeited and credited to the Benefit Plan Surplus.

Benefit Plan Surplus. Any forfeited amounts credited to the Benefit Plan Surplus (because you did not Incur a reimbursable expense or did not timely make a claim for reimbursement) may be separately accounted for after the end of the Coverage Period (or after a later time specified in this Plan for the filing of claims) in which the forfeitures arose. But due to Code rules, such forfeited amounts will not be carried over to the next Coverage Period, to reimburse you for expenses Incurred during such next Coverage Period, nor will amounts you forfeited be made available to you in any other form or manner, except as may be permitted by Treasury regulations and this Plan. Forfeited amounts credited to the Benefit Plan Surplus will be used to defray any administrative costs and experience losses, or otherwise used in a manner consistent with the Code and, as applicable, ERISA.

ARTICLE VI

ADMINISTRATION

Plan Administration. The operation of the Plan will be conducted by the Claims Administrator under the supervision of the Administrator. It will be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator will have full power to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code.

The Administrator has the greatest permissible discretion to construe the terms of the Plan and to determine all questions concerning eligibility, participation and benefits. Any such decision made by the Administrator will be binding on all Employees, Participants, and beneficiaries, and is intended to be subject to the most deferential standard of judicial review. Such standard of review is not to be affected by any real or alleged conflict of interest on the part of the Administrator. The Administrator's powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

- To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;
- To interpret the Plan, the Administrator's interpretations thereof to be final and conclusive on all persons claiming benefits under the Plan;
- To decide all questions (including questions of fact) concerning or related to the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided under the Plan;
- To reject online elections in the HR Benefits system or to limit contributions or Benefits for certain Highly Compensated Employees, Individuals or Participants, or Key Employees, if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;
- To provide Employees with a reasonable notification of their Benefits available under the Plan;
- To approve reimbursement requests and to authorize the payment of Benefits; and
- To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation, or construction taken by the Administrator will be done in a nondiscriminatory manner based upon uniform principles consistently applied, and will be consistent with the intent that the Plan comply with Section 125 of the Code and the regulations issued under that Section.

Named Fiduciary. The Administrator will be the named fiduciary pursuant to ERISA Section 402 and will be responsible for the management and control of the operation and administration of the Plan.

General Fiduciary Responsibilities. The Administrator and any other fiduciaries under ERISA will discharge their duties with respect to this Plan solely in the interest of you and your beneficiaries and:

- For the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;
- With the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and
- In accordance with the documents and instruments governing the Plan insofar as such documents and

instruments are consistent with ERISA.

Nonassignability of Rights. Your right to receive any reimbursement under the Plan cannot be assigned by you, and will not be made subject to the rights of your creditors. Any attempt to cause such right to be subjected to your creditors will not be recognized, except to such extent required by law.

Examination of Records. The Administrator will make available to each Participant, Eligible Employee and any other Employee of the Employer, for examination at reasonable times during normal business hours, any records that pertain to his or her interest under the Plan.

Payment of Expenses. The Employer will pay any reasonable administrative expenses, unless the Employer decides that administrative costs will be paid by Participants under the Plan or by any Trust Fund that may be established in connection with the Plan. The Administrator and/or its designee may impose reasonable conditions for payments, but such conditions will not discriminate in favor of Highly Compensated Employees.

Fraud. The benefits under this Plan are for you and your eligible dependents only. If you or any one of your dependents makes a false representation to or commits any other fraud with respect to the Plan, the Administrator may permanently terminate coverage for you and your dependents and seek reimbursement for any claims or expenses paid by the Plan as a result of the fraud. The Administrator may also pursue legal action against you.

Recovery of Payments Made by Mistake. You will be required to return to your Employer any benefits, or portion thereof, paid under the Plan by a mistake of fact or law. The Plan reserves the right to offset any the amounts due and payable by you from the payment of benefits that are payable to you.

Insurance Contracts May Control Over Terms of this Plan. If there is a conflict between the terms of this Plan and the terms of an Insurance Contract of a particular Insurer whose product is being used in conjunction with this Plan, the terms of the Insurance Contract will control with respect to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract will control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

Indemnification of Claims Administrator and Administrator. The Employer agrees to indemnify and to defend to the fullest extent permitted by law the Claims Administrator and any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against the following: all liabilities, damages, costs and expenses (including reasonable attorneys' fees and amounts paid in settlement of any claims approved by the Employer) caused by or resulting from any act of, or omission to act by, the Claims Administrator or any such Employee) in connection with the Plan, if such act or omission is in good faith.

Power and Authority of Insurance Companies. Certain benefits under the Plan are fully insured. These benefits are provided under group insurance contracts entered into between your Employer and the applicable insurance companies. Claims for benefits under these component programs are submitted to the insurance companies. The insurance companies, not your Employer, are responsible for determining and paying claims.
The insurance companies shall establish the claims procedures to be followed and the claims forms to be used by eligible individuals with respect to insured component benefits under the Plan

In their role as claims administrator, the insurers have the discretionary authority to interpret the Plan in order to make benefit determinations. The insurance companies also have the authority to require eligible individuals to furnish them with such information as they determine necessary for the proper administration of the Plan.

ARTICLE VII

AMENDMENT OR TERMINATION OF PLAN

Amendment. The Employer may at any time amend any provisions of the Plan without the consent of any other participating Employer, Employee, or Participant. No amendment will have the effect of modifying any online elections in the HR Benefits system of any Participant in effect at the time of the amendment, unless the amendment is made to comply with Federal, state or local laws, statutes or regulations.

Termination. The Employer has established this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate the Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions will be made. Benefits under any Insurance Contract will be paid in accordance with the terms of the Insurance Contract.

Upon termination, no further additions will be made to your Reimbursement Accounts described in the Appendices. However, all payments from your Reimbursement Accounts will continue to be made, according to the online elections in the HR Benefits system in effect, until the earlier of two dates. The two dates are: (1) the end of the Coverage Period in which the Plan termination occurs (and for a reasonable period of time thereafter, if required for the filing of claims), and (2) the date on which the balances of all Reimbursement Accounts have been reduced to zero. Any amounts remaining in any such Reimbursement Accounts as of the end of the Coverage Period in which Plan termination occurs will be forfeited and deposited in the Benefit Plan Surplus after the expiration of the claim filing period.

ARTICLE VIII

DEFINITIONS

"Administrator" means the individual(s) or corporation responsible for carrying out or overseeing the administration of the Plan. The Administrator is The Reinalt-Thomas Corporation d/b/a Discount Tire / America's Tire / Discount Tire Direct. If the Administrator is not the Employer, and resigns from a prior appointment and no successor Administrator is appointed, the Employer will be the Administrator.

"Benefit" means any of the benefits available under the Plan. These benefits are described in Article I.

"Benefit Plan Surplus" means amounts you forfeit and that are credited to such surplus as described in Appendices A and B, as applicable.

"Claims Administrator" means Discovery Benefits.

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

"Compensation" means the total cash compensation you receive from the Employer during a Coverage Period, prior to any reductions under your online elections in the HR Benefits system authorized under this Plan. "Compensation" includes overtime, commissions and bonuses.

"Coverage Period" means the period for which certain Benefits are provided to you under the Plan. The Coverage Period will be no less than 12 months, except that the Plan's first Coverage Period may, if it is commensurate with the Plan's fiscal year, be a short Coverage Period, and except where the Plan changes its fiscal year. In the event your participation begins during a Coverage Period, your initial Coverage Period is the portion of the Coverage Period remaining, beginning on the date your participation begins, and ending on the last day of that Coverage Period. The Plan may have different Coverage Periods for different Benefits, and a Coverage Period may be different than the Plan's fiscal year.

There is a single Coverage Period for all Benefits under the Plan. The Coverage Period is:
January 1 to December 31.

"Dependent" means any individual who, with respect to you, is a "qualifying child" or "qualifying relative" for the taxable year under Section 152 of the Code as determined without regard to subsections 152(b)(1), (b)(2) or (d)(1)(B). Generally, this requires the individual to (i) be your child, parent, or other relative described in that Section, and (ii) rely upon you for over half of his or her support during the taxable year (special support rules apply in the case of a child of divorced or legally separated parents). In the case of a non-spouse Dependent who is not a child or relative described in Section 152, generally the individual must rely upon you for over half of his or her support, have the same principal place of abode as you, and reside with you as a member of your household in a manner that is not in violation of local law.

Notwithstanding anything in the preceding paragraph to the contrary, however, for purposes of your ability to (1) make pre-tax payment of Premiums under this Plan for health care coverage on behalf of a child and (2) obtain, under the Health Care Reimbursement Program, reimbursement of Medical Expenses on behalf of a child, "Dependent" shall also include any child of yours defined in Code Section 152(f)(1) (generally, your natural, step, foster and adopted child, or child placed with you for adoption) through the end of the calendar year in which the child attains age 26. This rule does not mean that a child described in Code Section 152(f)(1) is necessarily eligible for health care coverage to the end of such calendar year under a health care plan or program (other than the Health Care Reimbursement Program) funded through this Plan; the eligibility of a child for a benefit shall be determined by the specific terms of the health care plans or programs funded through this Plan.

"Dependent Care Reimbursement Account" means your account under the Dependent Care Reimbursement Program, to which Flexible Benefits Plan Dollars may be credited on your behalf, in accordance with your Flexible Spending Account online election in the HR Benefits system and from which this Plan will pay eligible dependent

care expenses incurred by you, as described in Appendix B.

"Dependent Care Reimbursement Program" means the program, under this Flexible Benefits Plan, under which Flexible Benefits Plan Dollars, contributed to your Dependent Care Reimbursement Account pursuant to your online elections in the HR Benefits system are used to pay eligible dependent care expenses incurred by you. The Program is described in detail Appendix B.

"Effective Date" means the effective date of this restatement: **January 1, 2019.**

"Election Period" means the annual period that precedes the beginning of a Coverage Period, and during which you may elect the Benefits you want to receive under this Plan during that Coverage Period.

"Eligible Employee" means any full-time Employee who works for the Employer for a period of 90 day(s) and has satisfied the following eligibility rules:

- With respect to the **Pre-Tax Health and Welfare Plan Premium Payment** feature under the Plan, an Employee is eligible as follows: Except as may be provided below, on the date he becomes eligible to participate in a health and welfare plan sponsored by the Employer. The eligibility rules of the health and welfare plan(s) are described in the plan(s), and are hereby incorporated into this Plan by reference.

- With respect to the **Health Care Reimbursement Program**, an Employee is eligible when he becomes eligible to participate in the Employer's other health and welfare plan(s).

- With respect to the **Dependent Care Reimbursement Program**, an Employee is eligible at the same time he becomes eligible for the Health Care Reimbursement Program.

"Employee" means any person who is employed by an Employer, but excluding the following persons (if any):

- Any individual who at any time during the Employer's taxable year is a ***more than 2% shareholder*** in the Employer, if the Employer is a subchapter S corporation; and any individual who is the spouse, child, parent or grandparent of the more than 2% shareholder
- ***independent contractors***, and any other person paid through accounts payable rather than payroll, even if such person is later determined to have been a common law employee
- ***leased employees*** within the meaning of Section 414(n) of the Code
- ***collectively bargained employees*** (that is, employees who are members of a collective bargaining unit)

"Employer" means The Reinalt-Thomas Corporation d/b/a Discount Tire / America's Tire / Discount Tire Direct, any successor that maintains this Plan, and any predecessor that has maintained this Plan.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

"Flexible Benefits Plan Dollars" means the amount available to you, pursuant to your online elections in the HR Benefits system described in Article IV, to purchase Benefits. Each dollar contributed to this Plan pursuant to your online elections in the HR Benefits system equals one Flexible Benefits Plan Dollar.

"Health Care Reimbursement Account" means your account under the Health Care Reimbursement Program of this Plan, to which Flexible Benefits Plan Dollars may be allocated on your behalf, pursuant to your Flexible Spending Account election in the online HR Benefits system Reduction Agreement, and from which this Plan will pay eligible Medical Expenses Incurred by you, your Spouse or other Dependents, as described in Appendix A.

"Health Care Reimbursement Program" means the program, under this Flexible Benefits Plan, under which Flexible Benefits Plan Dollars are contributed to your Health Care Reimbursement Account pursuant to your online elections in the HR Benefits system and used to pay eligible Medical Expenses Incurred by you, your Spouse or other Dependents. The Program is described in detail in Appendix A.

"Highly Compensated Employee" means an Employee described in Code Section 414(q) and the Treasury regulations issued under that Section.

"Highly Compensated Individual" means a person described in Code Section 125(e)(2) and the Treasury regulations issued under that Section.

"Highly Compensated Participant" means a person described in Code Section 125(e)(1) and the Treasury regulations issued under that Section.

"Insurance Contract" means any contract issued by an Insurer.

"Insurer" means any insurance company that underwrites a Benefit.

"Key Employee" means an Employee described in Code Section 416(i)(1) and the Treasury regulations issued under that Section.

"Participant" means any Eligible Employee who chooses to become a Participant under Article II and has not, for any reason, become ineligible to participate further in the Plan.

"Plan" means this document, including all amendments to this document.

"Premiums" mean the cost of your (and, where applicable, your Dependents') coverage under any or all of the health and welfare plans described in Article I under which you chose to be covered.

"Pre-Tax Health and Welfare Premium Account" means your account under this Plan to which Flexible Benefits Plan Dollars may be credited on your behalf, under your online elections in the HR Benefits system from which this Plan will pay Premiums for your (and, where applicable, your Spouse's and/or your other Dependents') coverage under one or more of the health and welfare benefit plans described in Article II. If you elect coverage under more than one benefit plan, a sub-account will be established for each such plan.

"Salary Reduction Agreement" means an agreement between you and your Employer under which you agree to reduce your Compensation through online elections in the HR Benefits (or to forego all or part of future increases in such Compensation) and to have such amounts contributed by the Employer to the Plan on your behalf. An online election in the HR Benefits system will apply only to Compensation that you have not actually or constructively received as of the date of the Agreement (after taking this Plan and Code Section 125 into account).

"Special Management Class" means members could be pre and post 65 and will need to coordinate with Medicare as appropriate.

"Spouse" means your legal opposite-sex husband or wife, as the case may be, unless legally separated by court decree. Your spouse will cease to be considered your "spouse" upon the entry of a decree of divorce or legal separation. To the extent required by the application of federal law, "Spouse" is limited to an opposite-sex Spouse.

"You" means an Employee.

ARTICLE IX

MISCELLANEOUS

Plan Interpretation. All provisions of this Plan will be interpreted and applied in a uniform, nondiscriminatory manner by the Administrator, as described in Article VI. This Plan will be read in its entirety and not severed, except as described below, in the section titled, *Severability*.

Gender and Number. Wherever any words are used in the masculine, feminine or neuter gender, they will be construed as though they were also used in another gender in all cases where they would so apply. Whenever any words are used herein in the singular or plural form, they will be construed as though they were also used in the other form in all cases where they would so apply.

Written Document. This Plan, in conjunction with any separate written document that may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any regulations promulgated thereunder relating to cafeteria plans.

Exclusive Benefit. This Plan will be maintained for the exclusive benefit of the Employees who participate in the Plan.

Participants' Rights. This Plan is not an employment contract between the Employer and any Participant or Employee, nor is it consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan will be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him as a Participant of this Plan.

Action by the Employer. Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act, it will be done and performed by a person duly authorized by the Employer.

Employer's Protective Clauses. Upon the failure of either you or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), your Benefits will be limited to the amounts described in the following sentence. The amounts described in this sentence are: (1) the insurance premium, if any, that remained unpaid for the period in question; and (2) the actual insurance proceeds, if any, received by the Employer or you as a result of your claim.

The Employer's liability to you will only extend—and be limited to—any payment actually received by the Employer from the Insurer. If the full insurance Benefit is not received by the Employer within a reasonable time after submission of a claim, the Employer will have no legal obligation whatsoever (except to execute any document called for by a settlement reached by you). You will be free to settle, compromise or refuse to pursue the claim as you, in your sole discretion, will see fit.

The Employer will not be responsible for the validity of any Insurance Contract issued under this Plan or with respect to which you purchase coverage under this Plan. Similarly, the Employer will not be responsible for the Insurer’s failure to make payments called for under any Insurance Contract, or for the action of any person that might delay or render null and void or unenforceable, in whole or in part, an Insurance Contract. With regard to this paragraph, the following will apply:

- Once insurance is applied for or obtained, the Employer will not be liable for any loss that might result from the failure to pay Premiums, where the Employer does not receive Premium notices.

- Where the Employer receives Premium notices, its liability for the payment of such Premiums will be limited to the amount of such Premiums and will not include liability for any other loss that may result from failure to pay such Premiums.

- The Employer will not be liable for the payment of any insurance Premium—or any loss that may result

from the failure to pay an insurance Premium—if the Benefits available under this Plan are insufficient to provide for the amount of such Premium cost at the time it is due. In these circumstances you will be responsible for and see to the payment of such Premiums. The Employer will attempt to notify you if available Benefits under this Plan are insufficient to provide for payment of an insurance Premium but will not be liable for any failure to make such notification.

No Guarantee of Tax Consequences. The Administrator and the Employer make no guarantee that any amounts paid to you or for your benefit under the Plan will be excludable from your gross income for federal or state income tax purposes. In addition, the Administrator and the Employer make no guarantee that any other federal or state tax treatment will apply to or be available to you. It will be your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income tax purposes, and to notify the Employer if you have reason to believe that any such payment is not so excludable.

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

Funding. The Plan is funded through salary reductions made by Participants. Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but will instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing in this Plan will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for your benefit, and neither you nor any other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

Other Salary-Related Plans. It is intended that any other salary-related employee benefit plans that are maintained or sponsored by the Employer will not be affected by this Plan. Any contributions or benefits under the other plans with respect to you will be based on your total compensation from the Employer, including any amounts by which your salary or wages may be reduced under Article IV. However, this rule will not apply to the extent not permitted by law or not otherwise provided for in such other plans.

Governing Law. The Code and the Treasury regulations issued under the Code (as they might be amended from time to time) govern this Plan. The Employer does not guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan will be construed, enforced and administered according to the laws of the State of Arizona.

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

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

Continuation of Coverage. In the event any Benefit under this Plan is subject to the continuation coverage requirement of Code Section 4980B or 42 U.S.C. § 300bb-1 (Public Health Service Act) and becomes unavailable, each Participant will be entitled to continuation coverage but only to the extent required in Code Section 4980B or 42 U.S.C. § 300bb-1, and regulations issued under the appropriate Section. In the event any Benefit under this Plan is subject to the continuation coverage requirement of the Uniformed Services Employment and Reemployment Rights Act and becomes unavailable on account of a Participant's uniformed service to which such Act applies, such Participant will be entitled to continuation coverage but only to the extent required in that Act and regulations issued under that Act.

Plan Records and Plan Numbers. Plan records are maintained on the basis of the Plan's fiscal year. The Plan Number is 525. The Plan Number for the Dependent Care Reimbursement Program is 525.

Plan's Fiscal Year. The Plan's fiscal year is: January 1 to December 31.

Employer's Information. The Employer's Tax Identification Number is: 38-1889682.

Administrator's Address and Telephone Number. The Administrator's address and telephone number are:

20225 North Scottsdale Road
Scottsdale, AZ 85255
(480) 606-6000

Agent for Service of Process. The Employer is the agent for service of process for the Plan.

Not in Place of Workers' Compensation. This Plan is not in place of and does not affect any requirement for coverage by Workers' Compensation insurance.

IN WITNESS WHEREOF, this Plan document is hereby adopted this 18th day of December, 2019, and will be effective as provided herein.

THE REINALT-THOMAS CORPORATION
D/B/A DISCOUNT TIRE / AMERICA'S TIRE /
DISCOUNT TIRE DIRECT

By _____

ATTEST: _____

APPENDIX A

HEALTH CARE REIMBURSEMENT PROGRAM

Establishment of Program. This Health Care Reimbursement Program is intended to qualify as a medical reimbursement plan under Code Section 105. It will be interpreted in a manner consistent with that Code Section and the Treasury regulations issued under that Section. If you choose to participate in the Health Care Reimbursement Program you may submit claims for the reimbursement of "Medical Expenses" (as defined below). All amounts reimbursed under this Health Care Reimbursement Program will be paid from amounts credited to your Health Care Reimbursement Account in accordance with your online elections in the HR Benefits system. Except as otherwise provided in this Appendix, for a Medical Expense to be reimbursed from the benefit you elected for a Coverage Period, the Medical Expense must be incurred within the Coverage Period.

Definitions. For the purposes of this Appendix and the Flexible Benefits Plan:

> ***"Medical Expenses"*** means expenses for medical care that meet the following requirements. First, the expense must fall within the meaning of the term "medical care" or "medical expense" as defined in Code Section 213 (and the rulings and Treasury regulations issued under that Section). Second, you may not deduct the expense from your gross income for purposes of determining your income tax. Medical Expenses do not include a medicine or drug unless such medicine or drug is a prescribed drug (but note the prescribed medicine or drug may be an over-the-counter medicine or drug if obtained with a valid prescription) or is insulin. ***This Program will not reimburse you for the cost of other health coverage, such as premiums paid under plans maintained by your Spouse's or other Dependent's employer or individual policies maintained by you or your Spouse or other Dependent.***
>
> ***"Incur" or "Incurred"*** with respect to an expense means the following: An expense is Incurred at the time the service giving rise to the expense is furnished, and not when the individual is formally billed for, is charged for, or pays for the service. Special rules may apply with respect to a course of treatment such as orthodontic care, where payment is required in advance.

The definitions of Article VIII are incorporated into this Appendix to the extent necessary to interpret and apply the provisions of this Health Care Reimbursement Program.

Forfeitures. The amount in your Health Care Reimbursement Account as of the end of any Coverage Period (and after the processing of all claims for that Coverage Period pursuant to rules described below) will be forfeited and credited to the Benefit Plan Surplus. In that case, you will have no further individual claim to such amount for any reason. Forfeited amounts may include amounts credited to your Account and with respect to which checks were issued by the Health Care Reimbursement Program administrator but which remain uncashed after a reasonable period of time, as determined by the Employer or administrator in its sole discretion.

Notwithstanding any other provision in this Appendix to the contrary, a special rule applies where, with respect to any Plan Year ending after May 19, 2005, as of the end of a Coverage Period you are both (i) enrolled in the Program (as either an active Employee or a COBRA beneficiary) and (ii) maintain a positive balance with respect to your Health Care Reimbursement Account. In that event, such positive balance may be applied to reimburse you for allowable Medical Expenses incurred by you, your Spouse or an eligible Dependent either in such Coverage Period, or within 2-1/2 months after the end of such Coverage Period (the "grace period"), provided the Claims Administrator has agreed to administer such a grace period, and a proper claim for reimbursement is properly submitted for reimbursement within the time prescribed below.

To the extent the Claims Administrator agrees to do so, reimbursable Medical Expenses incurred during the grace period will be reimbursed first from the positive balance remaining as of the close of the last day of the prior Coverage Period, and then from benefits you elected for the current Coverage Period. Where a claim is so reimbursed, exhausting the prior year's Health Care Reimbursement Account balance, and thereafter you timely submit additional claims incurred during such prior Coverage Period (or a previously denied claim is approved, for expenses incurred during such prior Coverage Period), a special rule applies.

In such event, the Claims Administrator may, in its discretion, (i) recharacterize the previously paid "grace period" claims as claims payable from the benefits you elected for the current Coverage Period, (ii) restore the balance remaining as of the close of the prior Coverage Period, and (iii) apply such balance to pay the additional claims incurred in the prior Coverage Period (or, as the case may be, the previously denied claims where an appeal of the denial is sustained).

Your continued coverage under the grace period shall continue to the end of the grace period notwithstanding your termination of employment (on or before the last day of the grace period) that would otherwise have operated to make you ineligible.

Qualified Reservist Distributions. If during the Coverage Period for the Health Care Reimbursement Program an Employee participating in the Program is called, as a member of a reserve component defined in Section 101 of Title 37 of the United States Code, to active duty for a period of at least 180 days (or for an indefinite period), the Plan shall, upon written request of such Employee on a form or in such manner as the Employer may direct, make to the Employee a distribution of the balance then credited, as of the date of such distribution, to such Employee's Health Care Reimbursement Account under the Program, subject to the following requirements:

- The Employee's balance on the date of the distribution must exceed zero; the balance on the date of the distribution is the sum of the contributions credited to the Employee's Health Care Reimbursement Account for the Coverage Period, as of the date of the distribution, less the amount of claims paid under the Program, as of the date of distribution, to the Employee for Medical Expenses Incurred during the Coverage Period;

- The Employee requests the distribution prior to the end of the Coverage Period, or the grace period, if any, applicable to such coverage period; and

- The Employer is able to make the distribution within 60 days after a valid request for the distribution is received.

Upon the payment of the distribution, the Employee's participation in the Health Care Reimbursement Program shall terminate, and any claims (with respect to the Coverage Period) Incurred but unpaid as of the date of the distribution or Incurred after that date shall not be payable; provided, however, that covered claims incurred during the Coverage Period and prior to the Plan's receipt of the request for the qualified reservist distribution shall be paid to the extent of (a) minus (b), where (a) is the Benefit elected by the Employee for the Coverage Period, and (b) is the sum of covered claims paid to the Employee, for the Coverage Period, as of the date of the qualified reservist distribution, and the amount of such distribution.
The amount of the distribution shall be treated as taxable income to the Employee and subject to employment taxes, except to the extent the Employee's distribution includes after-tax contributions from the Employee (e.g., COBRA premium payments).

The terms and conditions of this special rule shall be construed and applied in a manner consistent with applicable federal law.

Limitation on Allocations. The maximum amount of Flexible Benefits Plan Dollars your Employer will credit to your Health Care Reimbursement Account for any Coverage Period is:
$2,700.00 and the minimum is $50.00

Health Care Reimbursement Program Claims. Medical Expenses that you, your Spouse or other Dependents incur may be reimbursed even though the submission of the claim occurs after your participation under the Plan ends. However, the Medical Expenses must have been incurred while you were a Participant, and the claims must be filed with the Claims Administrator within the time described in below.

Generally, the claim will include a written statement (e.g., a receipt) from an independent third party (such as the health care provider that provided the service) stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, you must provide a written statement that the Medical Expense has not been reimbursed

or is not reimbursable under any other health care plan coverage and, if reimbursed from the Health Care Reimbursement Account, such amount will not be claimed as a tax deduction. *However, see the discussion below about electronic claim submissions where a debit or credit card is provided for your use by the Health Care Reimbursement Program Claims Administrator.* The Claims Administrator will retain a file of all such claim forms.

The Claims Administrator will direct the reimbursement to you of all allowable Medical Expenses, up to a maximum equal to the amount of Flexible Benefits Plan Dollars you chose—in your online elections in the HR Benefits system—to have the Employer contribute to your Health Care Reimbursement Account for the Coverage Period. ***Reimbursements will be made available to you throughout the Coverage Period without regard to the amount of Flexible Benefits Plan Dollars that have been credited to your Account at any given point in time.***

Example: Assume you choose in your online elections in the HR Benefits system to contribute $1,200 to the Health Care Reimbursement Program for the Coverage Period, in increments of $100 per month. The Coverage Period is the calendar year. During January, the Employer reduces your Compensation by $100, converts those dollars into Flexible Benefits Plan Dollars and credits them to your Health Care Reimbursement Account. In that same month, you incur an expense of $500 that is reimbursable under the Program. The claim is properly payable, even though at the time the claim is submitted you have only $100 Flexible Benefits Plan Dollars credited to your Account.

In addition, you will be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan that may be sponsored by the Employer, any governmental agency or any other plan covering you and/or you Spouse or other Dependents.

Claim Filing Deadline. A claim for the reimbursement of Medical Expenses Incurred in any Coverage Period will be decided within a reasonable time after it is received. However, if you fail to submit a properly executed claim before the end of the claim filing deadline, the claim will not be accepted. The claim filing deadline is: **90 days after the close of the Coverage Period.**

Notwithstanding the foregoing, with respect to Plan Years ending after May 19, 2005, allowable Medical Expenses incurred by you, your Spouse or an eligible Dependent during a Coverage Period (or within 2-1/2 months after the close of the Coverage Period) may be considered by the Health Care Reimbursement Program for payment from your Health Care Reimbursement Account for such Coverage Period, provided a proper claim therefore is made not later than **90 days after the close of such 2-1/2 month period.**

A claim will be deemed submitted when the Claims Administrator receives the completed claim form. However, if a claim form is filed by U.S. Postal Service, it will be deemed to have been submitted on the date of the United States postmark stamped on the envelope in which the claim form is mailed. Claims will be decided in accordance with Article V.

Notwithstanding the foregoing, see the discussion below about electronic claim submissions where a debit or credit card is provided for your use by the Health Care Reimbursement Program Claims Administrator.

Claim Payments Are Made to You. Except where this Program provides for your use of a debit or credit card to obtain services and supplies that would otherwise have been reimbursable under the Program had you paid cash for them, reimbursements under this Program will be made directly to you. In the event a payment from this Plan is made by check and such check is not negotiated by the payee within a reasonable time, the Plan Administrator may direct that such payment be forfeited, escheated to the State, or otherwise dealt with in such manner as the Employer may decide.

Debit or Credit Card Usage for Obtaining Covered Services and Supplies. The Employer may contract with the Claims Administrator to allow you to use a debit or credit card to access your Health Care Reimbursement Account. This allows you, where you obtain a service or supply from a provider that is willing to accept such debit or credit card transactions, to avoid having to pay cash for the service or supply, and then seek reimbursement from the Claims Administrator. However, your use of a debit or credit card is subject to specific and mandatory requirements imposed by the Claims Administrator, including (among other things), "after-the-fact" documentation or substantiation of the expense in some cases. If you fail to provide adequate after-the-fact documentation or

substantiation of an expense paid via a debit card, you agree that the Employer may deduct the amount of the expenses paid via the debit card from your wages, or set-off the amount you owe the Employer or the Program against future covered claims for Medical Expenses Incurred during the same Coverage Period and grace period.

COBRA Continuation Coverage. If you and/or your Spouse and/or other Dependent loses coverage under the Health Care Reimbursement Program due to a "qualifying event," you and/or your Spouse and/or Dependent, as the case may be, might be entitled to continue coverage for a period of time after the qualifying event, in accordance with the COBRA provisions of Article II and this Appendix.

"Qualifying events" include:

- Termination of your employment for any reason (including death), except for gross misconduct;
- Your termination of eligibility due to reduced work hours;
- Your eligibility for Medicare;
- Your divorce or legal separation; and
- A Dependent child's ceasing to satisfy the definition of "Dependent."

Under the law, you or the affected Spouse or Dependent has the responsibility to inform the Administrator of a qualifying event that is a divorce, legal separation, or a child losing Dependent status under this Plan within 60 days of the date of the later of the event or the date on which coverage would end under the Plan because of the event. The notice must be completed online in the HR Benefits system notifying the administrator of the qualifying event and the date it occurred.

When the Administrator is notified that one of these events has happened, the Administrator will in turn notify the person entitled to COBRA coverage ("qualified beneficiary") of his or her COBRA rights. Under the law, qualified beneficiaries have at least 60 days from the date coverage would be lost because of one of the events described above to inform the administrator that they want continuation coverage.

Special COBRA rights apply if you lose coverage as a result of termination or reduction of hours and you qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. You are entitled to a second opportunity to elect COBRA coverage for yourself and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which you begin receiving a trade readjustment allowance (or would be eligible to begin receiving the allowance but for the requirement to exhaust unemployment benefits) or begin receiving alternative trade adjustment assistance, but only if the election is made within the six months immediately after your group health plan coverage ended.

The duration for which a qualified beneficiary may purchase COBRA coverage depends on a number of factors. If the maximum amount of Benefits available to you under the Health Care Reimbursement Program does not exceed two times your salary reduction contribution for the year or, if greater, your salary reduction contribution plus $500, COBRA coverage is not available beyond the end of the grace period that follows the end of the Coverage Period in which the qualifying event occurred; in addition, if at the time of the qualifying event the amount available for reimbursement for the remainder of the Coverage Period is less than the amount of contributions the COBRA qualified beneficiary would be required to pay for the remainder of that Coverage Period, then the qualified beneficiary is not eligible for COBRA coverage under the Health Care Reimbursement Program. These rules are described in additional detail in Article II.

However, if the maximum amount of Benefits available to you under the Health Care Reimbursement Program exceeds two times your salary reduction contribution for the year or, if greater, your salary reduction contribution plus $500, COBRA coverage can continue for 18 months (for qualifying events that are a termination of employment (for reasons other than death) or reduction in work hours) or 36 months (for other qualifying events). If a qualified beneficiary is disabled (within the meaning of the Social Security Act) at the time of a qualifying event that is a termination of employment (for reasons other than death) or reduction in hours, or is so disabled during the first 60 days of COBRA coverage following such a qualifying event, COBRA coverage for that beneficiary—and any other qualified beneficiary affected by the same qualifying event—can continue for up to 29 months. Where there are multiple qualifying events the 18- or 29-month limit may be extended to 36 months.

You must pay for the COBRA coverage you elect, typically on an after-tax basis, in monthly amounts. For the remainder of the Coverage Period in which the qualifying event occurs the monthly amount is equal to the monthly amount you chose (in your Benefit Election Form) to pay during the Coverage Period, plus two percent. If COBRA coverage can be continued into a subsequent Coverage Period the monthly amount is equal to the $1/12^{th}$ of the total Benefits you elected to have available under the Program for that Coverage Period, plus two percent. Where a disabled qualified beneficiary continues COBRA coverage for the additional 11-month period described above, the surcharge per month is fifty percent rather than two percent during the 11- month extension.

A qualified beneficiary's continuation coverage may be cut short for any of the following three reasons:

- The Employer no longer provides group health coverage to any of its employees;
- The premium for continuation coverage is not paid on time; or
- The beneficiary becomes covered, after the date of the election of COBRA coverage, under Medicare or under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition he or she may have.

Payments are due monthly. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

For additional questions about continuation coverage, please contact the Administrator.

Continuation of Coverage Under USERRA. When an Eligible Employee participating in the Health Care Reimbursement Program commences a period of uniformed service to which the Uniformed Services Employment and Re-employment Rights Act applies, he or she may continue coverage under the Program, on a self-pay basis, for up to 24 months or, if shorter, the duration of the period of uniformed service. The Employer may prescribe reasonable procedures under which the Eligible Employee must elect and pay for this continued coverage, if the Eligible Employee chooses to continue the coverage.

Statement of ERISA Rights. As a participant in the Health Care Reimbursement Program under this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you shall be entitled to:

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

- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Program as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the

plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

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

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

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

Nondiscrimination Under Section 105(h). The Administrator may designate portions of the Health Care Reimbursement Program as separate plans for purposes of satisfying nondiscrimination testing under Section 105(h) of the Internal Revenue Code. In addition, where this Plan is included as a component program in a comprehensive health and welfare benefit plan that includes other health care benefits subject to Section 105(h), the Health Care Reimbursement Program may be designated as a separate testing plan, that is, it may be tested separately from other component health care programs included in such plan. Where the Administrator makes such a separate testing plan designation it shall disclose the separate testing plans to the Participants, to the extent required by applicable law or regulations.

APPENDIX B

DEPENDENT CARE REIMBURSEMENT PROGRAM

Establishment of Program. This Dependent Care Reimbursement Program is intended to qualify as a program under Code Section 129. It will be interpreted in a manner consistent with that Code Section and the Treasury regulations issued under that Section. If you choose to participate in this Program you may submit claims for the reimbursement of Employment-Related Dependent Care Expenses (defined below). All amounts reimbursed under this Dependent Care Reimbursement Program will be paid from amounts credited to your Account under this Program. **See the section at the end of this Appendix for information about whether the Dependent Care Reimbursement Program is more beneficial to you than the tax credit for dependent care expenses available to you under the Code.** Except as otherwise provided in this Appendix, for an Employment-Related Dependent Care Expense to be reimbursed from the benefit you elected for a Coverage Period, the Employment-Related Dependent Care Expense must be incurred within the Coverage Period.

Definitions. For the purposes of this Appendix and the Flexible Benefits Plan, the terms below will have the following meaning:

"Earned Income" means earned income as defined under Code Section 32(c)(2) (generally wages and salaries, plus net earnings from self-employment) but excluding amounts paid or Incurred by the Employer for dependent care assistance to you or on your behalf.

"Employment-Related Dependent Care Expenses" means expenses incurred by you for those services that, if paid by you, would be considered employment-related expenses under Code Section 21(b)(2). Generally, they include expenses for household services or for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable you to be gainfully employed for any period for which you have at least one Qualifying Dependent. Whether an amount qualifies as an Employment-Related Dependent Care Expense will be decided under the following rules:

- If the amounts are paid for expenses incurred outside your household, they will constitute Employment-Related Dependent Care Expenses only if Incurred for a Qualifying Dependent as defined below (if the Qualifying Dependent is not a Dependent child under the age of 13, the Qualifying Dependent must also regularly spend at least 8 hours each day in your household);

- If the expense is incurred outside your home at a facility that provides care for a fee, payment, or grant for more than six individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

- Your Employment-Related Dependent Care Expenses will not include amounts paid or incurred for service performed by a person who is your child (as defined in Code Section 151(c)(3)) and who is under the age of 19, or to an individual who is claimed as a Dependent by your or your Spouse (that is, an individual with respect to whom a personal exemption is claimed on your or your Spouse's federal income tax return).

- Expenses for "household services" means expenses paid for the performance in your home of ordinary and usual services necessary to the maintenance of your household. The expenses must also be attributable to the care of a Qualifying Dependent.

"Incur" or "Incurred" with respect to an expense means the following: An expense is incurred at the time the service giving rise to the expense is furnished, and not when the individual is formally billed for, is charged for, or pays for the service. Thus, with respect to Employment-Related Dependent Care Expenses, for example, services rendered for the month of June are not fully incurred until June 30th and cannot be reimbursed in full until then.

*"**Qualifying Dependent"*** means, for purposes of this Dependent Care Reimbursement Program:

- Your Dependent (as defined in Section 152(a)(1) of the Code (e.g. a "qualifying child") who is under the age of 13;

- Your Spouse or other Dependent who is physically or mentally incapable of caring for himself or herself, and who has the same principal place of abode as you, for over half the taxable year, and whose relationship with you is not in violation of local law at any time during the year; or

- Any other Dependent who is deemed to be a Qualifying Dependent described in one of the preceding two paragraphs, whichever is appropriate, pursuant to Code Section 21(e)(5) (dealing with special rules for establishing dependency in the case of divorced parents).

The definitions of Article VIII are incorporated into this Appendix to the extent necessary to interpret and apply the provisions of this Dependent Care Reimbursement Program.

Your Account Under this Program. The Claims Administrator will establish an Account under this Program for you when you choose to apply Flexible Benefits Plan Dollars to Dependent Care Reimbursement Program Benefits.

Increases and Decreases in Dependent Care Reimbursement Accounts. Your account under this Program will be increased each pay period by the portion of Flexible Benefits Plan Dollars that you chose to apply toward your account under this Program pursuant to your online elections in the HR Benefits system. Your account under this Program will be *reduced* by the amount of any Employment-Related Dependent Care Expense reimbursements paid or Incurred on your behalf, as described below in the section titled, *Dependent Care Reimbursement Program Claims.*

Allowable Dependent Care Reimbursement. Subject to (1) limitations reflected below, in the section titled, Limitations on Payments, and (2) the extent of the amount credited to your account under this Program, if you Incur Employment-Related Dependent Care Expenses you will be entitled to receive from the Program full reimbursement for the entire amount of such expenses Incurred during the Coverage Period (or portion of the Coverage Period) during which you are a Participant.

Annual Statement of Benefits. If you participate in this Program during a Coverage Period, then on or before January 31 of the ensuing Coverage Period the Employer will furnish to you a statement of all Benefits paid to you or on your behalf under this Program during the preceding Coverage Period.

Forfeitures. The amount credited to your account under this Program as of the end of any Coverage Period (and after the processing of all claims for such Coverage Period pursuant to the section below titled, *Coordination with Flexible Benefits Plan*) will be forfeited and credited to the Benefit Plan Surplus. In that case, you will have no further claim to such amount for any reason. Forfeited amounts may include amounts credited to your Account and with respect to which checks were issued by the Dependent Care Reimbursement Program administrator but which remain uncashed after a reasonable period of time, as determined by the Employer or administrator in its sole discretion.

Notwithstanding any other provision in this Appendix to the contrary, a special rule applies where, with respect to any Plan Year ending after May 19, 2005, you maintain a positive balance with respect to your Dependent Care Reimbursement Account as of the last day of the Coverage Period and are covered by the Dependent Care Reimbursement Program on such day. In that event, such positive balance may be applied to reimburse you for allowable Employment-Related Dependent Care Expenses incurred by you either in such Coverage Period, or within 2-1/2 months after the end of such Coverage Period (the "grace period"), provided the Claims Administrator has agreed to administer such a grace period, and a proper claim for reimbursement is properly submitted for reimbursement within the time prescribed below.

To the extent the Claims Administrator agrees to do so, reimbursable Employment-Related Dependent Care Expenses incurred during the grace period will be reimbursed first from the positive balance remaining as of the close of the last day of the prior Coverage Period, and then from benefits you elected for the current Coverage

Period. Where a claim is so reimbursed, exhausting the prior year's Dependent Care Reimbursement Account balance, and thereafter you timely submit additional claims incurred during such prior Coverage Period (or a previously denied claim is approved, for expenses incurred during such prior Coverage Period), a special rule applies.

In such event, the Claims Administrator may, in its discretion, (i) recharacterize the previously paid "grace period" claims as claims payable from the benefits you elected for the current Coverage Period, (ii) restore the balance remaining as of the close of the prior Coverage Period, and (iii) apply such balance to pay the additional claims incurred in the prior Coverage Period (or, as the case may be, the previously denied claims where an appeal of the denial is sustained).

Your continued coverage under the grace period shall continue to the end of the grace period notwithstanding your termination of employment (on or before the last day of the grace period) that would otherwise have operated to make you ineligible.

Limitation on Payments. Amounts paid from your account under this Program, in or on account of any single taxable year, will not exceed:

- the Earned Income limitation described in Code Section 129(b), or
- $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)), whichever is less.

Dependent Care Reimbursement Program Claims. You are required to file a claim with the Claims Administrator in order to receive Benefits from this Program. The claim must be in a form satisfactory to the Claims Administrator, and must include a statement from an independent third party (for example, the caregiver) as proof that the expense has been Incurred, and the amount of such expense. In addition, the Claims Administrator may require that the claim include a statement containing the following information:

- The name and age of each Dependent for whom the services were performed.
- The nature and dates of the services that were performed.
- Your acknowledgment that you will include on your federal income tax return the name, address, and (except in the case of a tax-exempt provider) the taxpayer identification number of the provider (or will exercise due diligence in attempting to obtain such information).
- The relationship, if any, of the person performing the services for you.
- If another of your Dependents performed the services, the age of the other Dependent.
- Where the services were performed.
- If any of the services were performed outside your home, whether the Dependent for whom such services were performed regularly spends at least 8 hours each day in your household.
- If the services were performed in a day care center that provides care for more than six individuals (other than individuals residing at the center) and receives a fee, payment, or grant for providing any of such care:
    - Whether the day care center complies with all applicable state and local laws and regulations of the state of residence, and
    - The amount of the fee, payment, or grant paid to the provider.
- If you are married:
    - Whether you and your Spouse plan to file a joint return or separate returns of federal income taxes; and
    - The amount, if any, of nontaxable dependent care assistance benefits received from any other employer by you or your Spouse for the Coverage Period.

Claim Payments Are Made to You. The Claims Administrator will pay Benefits under this Program directly to you or, in the Claims Administrator's discretion, directly to the service provider. In the event a payment from this Plan is made by check and such check is not negotiated by the payee within a reasonable time, the Plan Administrator may direct that such payment be forfeited, escheated to the State, or otherwise dealt with in such manner as the Employer may decide.

A claim for the reimbursement of Employment-Related Dependent Care Expenses Incurred in any Coverage Period will be decided within a reasonable time after it is received. However, if a Participant fails to submit a properly executed claim form within the claim filing deadline, the Claims Administrator will not consider the claim. The claim filing deadline is: **90 days after the close of the Coverage Period.**

Notwithstanding the foregoing, with respect to Plan Years ending after May 19, 2005, Employment-Related Dependent Care Expenses incurred by you during a Coverage Period (or within 2-1/2 months after the close of the Coverage Period) may be considered by the Dependent Care Reimbursement Program for payment from your Dependent Care Reimbursement Account for such Coverage Period, provided a proper claim therefore is made not later than **90 days after the close of such 2-1/2 month period.**

The Claims Administrator will deem a claim to have been submitted when the Claims Administrator receives the claim form. However, if a claim form is filed by U.S. Postal Service, the Claims Administrator will deem it to have been submitted on the date of the United States postmark stamped on the envelope in which the claim form is mailed. Claims will be decided in accordance with the rules in Article V.

Nondiscrimination Requirements. It is the intent of this Dependent Care Reimbursement Program that:

- Contributions or Benefits not discriminate in favor of Highly Compensated Employees or their Dependents, as prohibited by Code Section 129(d), and

- Not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Coverage Period be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Coverage Period) owns more than 5 percent of the stock or the capital or profits interest in the Employer.

If the Claims Administrator deems it necessary to avoid discrimination or possible taxation to Highly Compensated Employees (as defined under Article VIII) or to principal shareholders or owners as described above, it may reject any online elections in the HR Benefits system or reduce contributions or nontaxable benefits in order to assure compliance with these rules. Any act taken by the Claims Administrator under these rules will be carried out in a uniform and nondiscriminatory manner. If the Claims Administrator decides to reject any online elections in the HR Benefits system or reduce contributions or Benefits, it will be done in the following manner. First, the Benefits designated for the account under this Program of the Highly Compensated Employee that elected to contribute the highest amount to such account for the Coverage Period will be reduced until the nondiscrimination tests set forth in these rules are satisfied, or until the amount designated for the account equals the amount designated for the account of the Highly Compensated Employee who has elected the second highest contribution to an account under this Program for the Coverage Period. This process will continue until the nondiscrimination tests described above are satisfied.

Coordination with Flexible Benefits Plan. All Participants under the Flexible Benefits Plan are eligible to receive Benefits under this Dependent Care Reimbursement Program. The enrollment and termination of participation under the Flexible Benefits Plan will constitute enrollment and termination of participation under this Dependent Care Reimbursement Program. In addition, other matters concerning contributions, online elections in the HR Benefits system and the like will be governed by the general provisions of the Flexible Benefits Plan.

What You Should Know — Comparison of the Dependent Care Reimbursement Program and the Dependent Care Tax Credit. Many people find it necessary to pay for the care of their children or other dependents so that they can work outside of the home. If that is your situation, you may be eligible for certain tax benefits provided in the Code. This subsection describes two of those benefits, so that you can judge which would be best suited to your own circumstances.

The Code helps you to pay for dependent care expenses in two different ways. First, it may be possible to exclude from your taxable income a portion of the dependent care expenses you incur. Second, you may receive a credit against your taxes equal to a portion of such expenses. Although the exclusion and credit are calculated in entirely different ways, they are both subject to essentially the same eligibility requirements. Moreover, the dependent care expenses to which each applies are limited to the earned income of you or your Spouse, whichever is smaller. These

requirements and limitations are described in earlier sections of this Appendix. The remainder of this discussion will assume that you are eligible for at least a certain level of both such benefits.

Dependent Care Exclusion. You will note that the dependent care exclusion is described in earlier sections of this Appendix. The exclusion works like this. You elect to have the Employer withhold a portion of your Compensation each month and contribute that amount to your account under this Plan's Dependent Care Reimbursement Program. Those amounts, up to the maximum set forth in this Appendix, may be used to pay for the expenses of dependent care, and are then excluded from the amount of compensation reported on your Form W-2. In other words, this would not be a deduction (which you would have to itemize on your income tax return), but would simply never be considered a part of your income.

The actual benefit of such dependent care exclusion would depend on your income tax bracket. For example, if you were in a 15% tax bracket, the monetary benefit of $5,000 dependent care exclusion would be 15% of that amount, or $750. If you were in a 28% bracket would receive a $1,400 benefit from the full $5,000 exclusion.

Dependent Care Credit. The dependent care credit is entirely different from the exclusion described above. A credit is applied directly against the amount of taxes you would otherwise pay at the end of the year. To calculate the estimated credit, you must know your tax bracket, your adjusted gross income, how much you spend on daycare & how many qualified dependents you have.

For additional assistance in deciding whether to elect to participate in the Plan's Dependent Care Assistance Benefit, to claim the Dependent Care Credit, or both, please consult your tax advisor.

APPENDIX C

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 PRIVACY REQUIREMENTS

Introduction. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes upon this Plan and certain other entities certain responsibilities to ensure that Protected Health Information ("PHI") pertaining to covered persons remains confidential, subject to limited exceptions in which PHI may be disclosed. "Protected Health Information" means health information (including oral information) that:

- is created or received by a health care providers, health plans, or health care clearinghouses;
- relates to an individual's past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and
- identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

Effective Date. The rules contained in this Article do not apply to the Plan or the Employer until such date as the HIPAA Privacy regulations (45 C.F.R. § 160.101 et seq.) apply to the Plan.

Disclosures Of PHI By The Plan To The Employer. Provided that the Plan (or the Employer on behalf of the Plan) provides to covered person a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI to the Employer, the Plan may disclose PHI (relating to a covered person) to the Employer, as further described below, without the consent or authorization of the covered person. In no event may the Plan disclose PHI to the Employer, without the consent or authorization of the covered person or his authorized representative, for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

The Plan may disclose PHI to the Employer, without the consent or authorization of the covered person, subject to the Employer's obligations described below (in the section titled, *Employer Obligations with Respect to PHI Obtained from the Plan*) for Plan administrative functions such as quality assurance, claims processing, auditing, and monitoring. However, only the minimum amount of PHI necessary to accomplish a particular Plan administration function may be disclosed to the person(s) performing such functions.

In addition to disclosing PHI to the Employer to allow the Employer to perform Plan administrative functions, the Plan may disclose certain limited summary health information to the Employer, without the consent or authorization of the covered person, for purposes such as obtaining premium bids for health insurance or reinsurance, or for modifying, amending or terminating the Plan. "Summary health information" is health information that summarizes claims history, expenses, or types of claims by individuals, but from which has been removed at least 18 specific identifiers, including names, dates (except year), telephone numbers, Social Security numbers, medical record numbers, and other identifiers. In addition, the Plan may disclose enrollment and disenrollment information to the Employer without the consent or authorization of the covered person.

Employer Obligations With Respect To PHI Obtained From The Plan. As a condition of receiving PHI from the Plan for Plan administrative functions the Employer specifically agrees to:

- not use or further disclose the PHI other than as permitted by this Plan or as required by law, or as permitted by the covered person to whom the PHI relates;
- ensure that any agents or subcontractors to whom it shares or provides the PHI received from the Plan agree to these same restrictions and conditions;
- not use the PHI for employment-related actions or in connection with any of its other benefit plans without the consent or authorization from the covered person to whom the PHI relates;
- report to the Plan any improper uses or disclosures of the PHI;
- provide covered persons access to PHI that relates to them, allow them to request amendments to the PHI, and upon request provide covered persons an accounting of all disclosures of their PHI by the Employer

(except for those disclosures with respect to which no accounting is required);

- make available to appropriate federal authorities the Employer's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan; and
- return or destroy (to the extent feasible) all copies of the PHI received from the Plan once the Employer's need for which the PHI was requested no longer exists or, if this is not feasible, limit further uses and disclosures of the PHI.

Use And Disclosure Of PHI By The Employer; Dispute Resolution. When the Employer obtains PHI from the Plan for Plan administrative functions, the PHI will be provided to the human resources or employee benefits department of the Employer, and may also be provided to the Employer's payroll department (for purposes of processing payroll deductions for payment of premium) and chief financial officer and his designees. The persons in these departments, except as otherwise provided in a specific authorization granted by the covered person or his authorized representative to the Employer, will have access to and may use the PHI solely to perform Plan administrative functions that the Employer performs for or with respect to the Plan.

The Employer may use PHI that it receives from the Plan to carry out Plan administrative functions and may use summary health information for the purposes described in section above titled, *Disclosures of PHI by the Plan to the Employer.* The Employer may also disclose PHI relating to a covered person, without the consent or authorization of the covered person, as required or as otherwise permitted by law. For example, the law allows PHI to be disclosed, without the consent or authorization of the covered person, to law enforcement, public health, and judicial agencies in certain circumstances. PHI pertaining to a minor covered person may, to the extent permitted by local law, be disclosed to the covered person's parent or guardian without the consent or authorization of the minor. There are other situations in which PHI may be disclosed without the covered person's consent. For more information please review the Plan's Privacy Notice or see the Plan's Privacy Official.

In the event a covered person or any other person believes that the Employer or any of its agents have misused PHI disclosed to it or to them by the Plan, such persons may notify the Employer's Privacy Official (contact the human resources or employee benefits department for more information regarding how to contact the Privacy Official), or may file a complaint as described in the Plan's Privacy Notice, a copy of which you should have already received (an additional copy is available from the human resources or employee benefits department). If the complaint is filed with the Privacy Official the Privacy Official will investigate the complaint and the events and circumstances related to it, as provided in the Employer's Privacy Policy and Procedure.

APPENDIX D

Newborns' and Mothers' Health Protection Act Notice

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

Women's Health and Cancer Rights Act Notice

As a participant of the Plan, if you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. Please see your medical program booklet for deductibles. If you would like more information on WHCRA benefits, please contact Human Resources.

Patient Protections Under PPACA

Reinalt-Thomas Corporation Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 800-347-4348

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Reinalt-Thomas Corporation Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Human Resources.

Wellness Programs: Availability of Reasonable Alternative

The Plan is committed to helping you achieve your best health. Rewards for participating in the Plan's wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your local Human Resources Department and we will work with you (and, if you wish, your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Statement of ERISA Rights

As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you are entitled to:

Receive Information About Your Plan and Benefits

- Examine without charge at the Plan Sponsor's offices all Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as annual financial reports (Form 5500 Series).

- Obtain copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive summaries of the Plan's annual financial reports. These summaries are prepared and distributed to Plan participants each year. The Plan Administrator is required by law to furnish each participant a copy of the summary annual report.

Continue Group Health Plan Coverage

- Under a group health plan, continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan regarding the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may discharge you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court after you have exhausted the Plan's claims procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you

are successful, the court may order the Plan Administrator to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance With Your Questions.

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

Health Insurance Portability and Accountability Act of 1996

* This notice pertains only to healthcare coverage provided under the plan.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Reinalt-Thomas Corporation that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
  - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

  - **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its

payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
  - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Reinalt-Thomas Corporation) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
  - **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
  - **Required by Law**: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
  - **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
  - **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
  - **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
  - **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
  - **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
  - **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose

your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Human Resources
800-347-4348

GENERAL COBRA NOTICE

October 7, 2019

Re: CONTINUATION COVERAGE RIGHTS UNDER COBRA

You are receiving this Notice of COBRA healthcare coverage continuation rights because you have recently become covered under one or more group health plans. The plan (or plans) under which you have gained coverage are listed at the end of this Form, and are referred to collectively as "the plan" except where otherwise indicated.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of healthcare coverage under the plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and/or to other members of your family who are covered under the plan when you and/or they would otherwise lose the group health coverage. This notice gives only a summary of your COBRA continuation coverage rights. ***This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.*** For more information about your rights and obligations under the plan and under federal law, you should either review the plan's Summary Plan Description or contact the Plan Administrator. In some cases the plan document also serves as the Summary Plan Description.

Note you may have other options available to you when you lose group health coverage. When you become eligible for COBRA, you may also become eligible for other coverage options not provided by your employer that may cost less than COBRA continuation coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Continuation Coverage and "Qualifying Events"

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and eligible children of employees may be qualified beneficiaries. Certain newborns, newly-adopted children and alternate recipients under qualified medical child support orders may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below. Under the plan, qualified beneficiaries who elect COBRA continuation coverage generally must pay for this continuation coverage.

If you are a covered ***employee***, you will become a qualified beneficiary if you lose your coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the ***spouse of a covered employee***, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in any part of Medicare (it is extremely rare for coverage of an employee's dependents to be terminated on account of the employee's Medicare enrollment); or

- You become divorced or legally separated from your spouse. Note that if your spouse cancels your coverage in anticipation of a divorce or legal separation and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though you actually lost coverage earlier. ***If you notify the Plan Administrator or its designee within 60days after the divorce or legal separation and can establish that the employee canceled the coverage earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for a period after the divorce or legal separation (but not for the period between the date your coverage ended, and the date of divorce or legal separation).*** But you *must* provide timely notice of the divorce or legal separation to the Plan Administrator or its designee or you will not be able to obtain COBRA coverage after the divorce or legal separation. See the rules in the box below, under the heading entitled, *"Notice Requirements,"* regarding the obligation to provide notice, and the procedures for doing so.

Your covered ***eligible children*** will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in any part of Medicare (it is extremely rare for coverage of an employee's dependents to be terminated on account of the employee's Medicare enrollment);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as an "eligible child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Reinalt-Thomas Corporation, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and eligible children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

Notice Requirements

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been ***timely notified*** that a qualifying event has occurred. When the qualifying event is:

- the end of employment or reduction of hours of employment,
- death of the employee,
- commencement of a proceeding in bankruptcy with respect to the employer,; or the employer (if the employer is not the Plan Administrator) must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

IMPORTANT:

For the other qualifying events (divorce or legal separation of the employee and spouse or an eligible child's losing eligibility for coverage as an eligible child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or eligible child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:
Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Human Resources
20225 North Scottsdale Road
Scottsdale, AZ 85255

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the ***name of the plan or plans*** under which you lost or are losing coverage,
- the ***name and address of the employee*** covered under the plan,
- the ***name(s) and address(es) of the qualified beneficiary(ies)***, and
- the ***qualifying event*** and the ***date*** it happened.

If the qualifying event is a ***divorce*** or ***legal separation***, your notice must include ***a copy of the divorce decree or the legal separation agreement.***

There are other notice requirements in other contexts. See, for example, the discussion below under the heading entitled, "*Duration of COBRA Coverage.*" That explanation describes other situations where notice from you or the qualified beneficiary is required in order to gain the right to COBRA coverage.

Once the Plan Administrator receives *timely notice* that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. ***If you or your spouse or covered children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.***

Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in any part of Medicare, your divorce or legal separation, or an eligible child losing eligibility as an eligible child, COBRA continuation coverage lasts for up to ***36 months***.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to ***18 months***.

There are *three ways* in which the period of COBRA continuation coverage can be extended…

1. Disability extension of 18-month period of continuation coverage.

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled as of the date of the qualifying event or at any time during the first 60 days of COBRA continuation coverage ***and you notify the Plan Administrator or its designee in writing and in a timely fashion***, you and your entire family can receive up to ***an additional 11 months*** of COBRA continuation coverage, for a total maximum of ***29 months***.

You must make sure that the Plan Administrator or its designee is notified in writing of the Social Security Administration's determination within 60 days after (i) of the date of the determination or (ii) the date of the

qualifying event or (iii) the date coverage is lost due to the qualifying event, whichever occurs last. But in any event the notice must be provided before the end of the 18-month period of COBRA continuation coverage. The plan requires you to follow the procedures specified in the box above, under the heading entitled *"Notice Procedures."* In addition, your notice must include

- the name of the disabled qualified beneficiary,
- the date that the qualified beneficiary became disabled, and
- the date that the Social Security Administration made its determination.

Your notice must also include a copy of the Social Security Administration's determination. ***If these procedures are not followed or if the notice is not provided <u>in writing</u> to the Plan Administrator or its designee within the required period, then there will be no disability extension of COBRA continuation coverage.***

2. Second qualifying event extension of 18-month period of continuation coverage.

If your family experiences ***another qualifying event*** while receiving COBRA continuation coverage, the spouse and eligible children in your family can get additional months of COBRA continuation coverage, up to a maximum of ***36 months (including the initial period of COBRA coverage)***.

This extension is available to ***the spouse*** and ***eligible children*** if, while they and the covered former employee are purchasing COBRA coverage, the former employee:

- dies,
- enrolls in any part of Medicare
- gets divorced or legally separated.

The extension is also available to an ***eligible child*** when that child stops being eligible under the plan as an eligible child.

In all of these cases, you must make sure that the Plan Administrator or its designee is notified <u>in writing</u> of the second qualifying event within <u>60 days</u> after (i) the date of the second qualifying event or (ii) the date coverage is lost, whichever occurs last. The plan requires you to follow the procedures specified in the box above, under the heading entitled *"Notice Procedures."* Your notice must also ***name the second qualifying event*** and ***the date it happened***. If the second qualifying event is a divorce or legal separation, your notice must include ***a copy of the divorce decree or legal separation agreement***.

If these procedures are not followed or if the notice is not provided <u>in writing</u> to the Plan Administrator or its designee within the required <u>60-day</u> period, then there will be no extension of COBRA continuation coverage due to the second qualifying event.

3. ***Medicare Extension for Spouse and Eligible Children.***

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to any part of Medicare, then the maximum coverage period for the spouse and eligible children is ***36 months*** from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be 18 months).

Shorter Maximum Coverage Period for Health Flexible Spending Accounts

The maximum COBRA coverage period for a health flexible spending arrangement (health "FSA") maintained by the employer ends on the last day of the cafeteria or flexible benefits plan "plan year" in which the qualifying event occurred. In addition, if at the time of the qualifying event the employee has withdrawn (during the plan year) more from the FSA than the employee has had credited to the FSA, no COBRA right is available at all.

OTHER RULES AND REQUIREMENTS

Same Rights as Active Employees to Add New Dependents. A qualified beneficiary generally has the same rights as similarly situated active employees to add or drop dependents, make enrollment changes during open enrollment, etc. Contact the Plan Administrator for more information. See also the paragraph below titled, *"Children Born or Placed for Adoption with the Covered Employee During COBRA Period,"* for information about how certain children acquired by a covered employee purchasing COBRA coverage may actually be treated as qualified beneficiaries themselves. ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 31 days of the date you wish to make such a change*** *(adding or dropping dependents, for example).* See the rules in the box above, under the heading entitled, *"Notice Procedures,"* for an explanation regarding how your notice should be made.

Children Born to or Placed for Adoption with the Covered Employee During COBRA Period. A child born to, adopted by, or placed for adoption with a covered employee or former employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee or former employee is a qualified beneficiary, the employee has elected COBRA continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, age requirements). ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 31 days of the date you wish to make such a change.*** See the rules in the box above, under the heading entitled, *"Notice Procedures,"* for an explanation regarding how your notice should be made.

Alternate Recipients Under Qualified Medical Child Support Orders. A child of the covered employee or former employee who is receiving benefits under the plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the employee's period of employment with the employer is entitled the same rights under COBRA as an eligible child of the covered employee, regardless of whether that child would otherwise be considered a dependent. ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 31 days of the date you wish to make such a change.*** See the rules in the box above, under the heading entitled, *"Notice Procedures,"* for an explanation regarding how your notice should be made.

Are there other coverage options besides COBRA Continuation Coverage?

Yes, other coverage options not sponsored by your employer may be available. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your plan or your COBRA continuation rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability or Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at **www.dol.gov/ebsa.**"

Keep Your Plan Informed of Address Changes. In order to protect your family's rights, you should keep the Plan Administrator or its designee informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

Medicare Part D Creditable Coverage Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Reinalt-Thomas Corporation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Company has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Company coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Company coverage, be aware that you and your dependents will be able to get this coverage back pursuant to the terms of the Plan.

When Will You Pay A Higher Premium (Penalty) To Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Company and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact Human Resources, or call 800-347-4348 for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924	

CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565