MAGNA INTERNATIONAL OF AMERICA, INC.

WELFARE BENEFIT PLAN

Amended and Restated as of

January 1, 2026

PREAMBLE AND EXECUTION

WHEREAS, Magna International of America, Inc. ("the Company") maintains medical, dental, vision, employee assistance, group life and accidental death and dismemberment, short term disability, long term disability, business travel accident, health care spending account, dependent care spending account and cafeteria plan benefits for its employees and their eligible dependents and the employees and eligible dependents of each Participating Employer; and

WHEREAS, the Company has adopted the Magna International of America, Inc. Consolidated Welfare Benefit Plan, originally effective on August 1, 1990, and as most recently and amended and restated as of January 1, 2015 and renamed the Magna International of America, Inc. Welfare Benefit Plan, which sets forth provisions relating to medical, prescription drug, dental, vision, employee assistance, short term disability, health care spending account, and dependent care spending account benefits for eligible employees, each of which (other than vision and the employee assistance program) is funded through general assets, and provisions relating to group life and accidental death and dismemberment, long term disability and business travel accident benefits for eligible employees pursuant to the terms of group policies;

WHEREAS the Company has adopted the Magna International of America, Inc. Cafeteria Plan originally effective on January 1, 1993, as most recently amended and restated as of January 1, 2026;

WHEREAS, the Company desires to have a single plan document describing the relevant plan terms, but treat them as separate plans for ERISA reporting and disclosure purposes.

NOW, THEREFORE, by virtue and in exercise of the amending power reserved to the Company, the Magna International of America, Inc. Welfare Benefit Plan (the "Plan") is hereby amended and restated effective January 1, 2026, and covers the following three plans:

(1) The Magna International of America, Inc. Employee Welfare Benefit Plan (Plan Number 502), providing the following types of benefits:

- Medical
- Prescription Drug
- Dental
- Vision
- Employee Family Assistance Plan
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Short-Term Disability
- Retiree Premium Reimbursement

(2) The Magna International of America, Inc. Life Insurance Plan (Plan Number 510), providing the following types of benefits:

- Basic Life Insurance
- Supplemental Life Insurance

- Basic Dependent Life Insurance
- Supplemental Dependent Life Insurance
- Accidental Death and Dismemberment (AD&D)
- Supplemental AD&D
- Business Travel Accident Insurance

(3) The Magna International of America, Inc. Long Term Disability Plan (Plan Number 511), providing the following types of benefits:

- Core Long-Term Disability (LTD)
- Buy-Up LTD

IN WITNESS WHEREOF, the undersigned has caused the Plan to be executed by its duly authorized officer this _____ day of _____, 2025.

MAGNA INTERNATIONAL OF AMERICA, INC.

By _____

Title _____

and

By: _____

Title: _____

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ARTICLE I

PLAN ESTABLISHMENT

1.1 Effective Date

The Magna International of America, Inc. Welfare Benefit Plan (the “Plan") is amended and restated effective January 1, 2026.

1.2 Purpose

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

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

1.3 Qualification

To the extent this Plan provides specified health and welfare benefits, it is intended to satisfy the written plan document requirements of section 402 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The portion of the Plan that constitute the health and welfare plan under ERISA are: the Medical Benefits, Prescription Drug Benefits, Dental Benefits, Vision Benefits, Employee Assistance Benefits, Basic Life Benefits, Supplemental Life Benefits, Dependent Life Benefits, Supplemental Dependent Life Benefits, Basic AD&D Benefits, Supplemental AD&D Benefits, Core Long-Term Disability Benefits, Buy-up Long-Term Disability Benefits, Business Travel Accident Benefits, the Health Care Flexible Spending Account, Short Term Disability Benefits and Retiree Premium Reimbursement Benefits, along with those other provisions of this document that are necessary or appropriate to the implementation and administration of listed benefits ("ERISA Benefits"). The inclusion of the Dependent Care Spending Account, or references to a Health Savings Account ("Non-ERISA Benefits") in this Plan document and the inclusion of, or reference to, any other benefit that is not otherwise subject to ERISA shall not subject such benefit to ERISA.

The Cafeteria Plan allows Covered Employees to make Salary Reduction Contributions for Medical, Dental and Vision Benefits; to make pre-tax contributions to a Health Savings Account if they participate in a Company-sponsored high deductible health plan; and to elect coverage under the Health Care Flexible Spending Account and/or the Dependent Care Spending Account. The cafeteria plan is for Covered Employees only. To the extent there is a conflict between the Cafeteria Plan and this Plan, this Plan shall control.

The Dependent Care Spending Account Plan, as defined in Section 2.11 and set forth in Appendix A, is part of this Plan and is intended to qualify as a dependent care assistance program under section 129 of the Code. Appendix A, together with Article VII of the Cafeteria Plan, is intended to satisfy the written plan document requirement of Code section 129(d)(1).

The Health Care Spending Account Plan, as defined in Section 2.17 and set forth in Appendix B, is part of this Plan and is intended to be an employee welfare benefit plan under section 3(3) of ERISA. The Health Care Spending Account Plan is intended to qualify as a health plan under section 105(e) of the Code. Appendix B, together with Article VI of the Cafeteria Plan, is intended to satisfy the written plan document requirement of ERISA section 402 and Department of Treasury regulation section 1.105-11(b)(1)(i).

The Retiree Premium Reimbursement Plan, as set forth in its summary plan description, is part of this Plan and is intended to be an employee welfare benefit plan under section 3(3) of ERISA. The Retiree Premium Reimbursement Plan is intended to qualify as a health plan under section 105(e) of the Code. The summary plan description for the Retiree Premium Reimbursement Plan is intended to satisfy the written plan document requirement of ERISA section 402 and Department of Treasury regulation section 1.105-11(b)(1)(i).

1.4 Duration

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

ARTICLE II

DEFINITIONS

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

1.5 Benefits

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

The benefits under the Retiree Premium Reimbursement Plan are available only to eligible Retirees who meet the eligibility requirements of Section 2.31.

1.6 Break in Service

Break in Service means a period of:

A. Thirteen (13) consecutive weeks (or more) during which an Employee has no Hours of Service, or

B. At the Plan Administrator's discretion, four (4) or more consecutive weeks (up to 13 weeks) during which an Employee has no Hours of Service, if the period with no Hours of Service is greater than the immediately preceding period of employment.

1.7 Change in Status

Change in Status means:

A. a "special enrollment" event under HIPAA,

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

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

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

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

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

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

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

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

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

K. loss of "qualifying individual" status, as defined in Section 2.8 of the Dependent Care Spending Account Plan,

L. a change in status event affecting a nondependent child who has not attained age 26,

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

1.8 Claim Administrator

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

1.9 Code

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

1.10 COBRA

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

1.11 Company

Company means Magna International of America, Inc. a corporation, and any successor, by merger or otherwise. The Company is hereby designated as the "plan sponsor" for purposes of the Patient-Centered Outcomes Research Institute fee under Code section 4376.

1.12 Covered Employee

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

1.13 Covered Person

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

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

A Covered Person with respect to the Retiree Premium Reimbursement Plan means only a Retiree as defined in Section 2.31.

1.14 Dependent

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

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

A. Spouse,

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

C. for health Benefits for the Covered Employee's child as defined in Code section 152(f)(1) through the end of the month in which the child attains age 26.

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

The following individuals are not eligible for Medical, Dental or Vision Benefits, regardless of whether they are the "tax dependent" of a Covered Employee:

- A spouse or child living outside the United States; or
- The Covered Employee's parent or spouse's parent.

1.15 Dependent Care Spending Account Plan

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

1.16 Effective Date

Effective Date means the date this amended and restated Plan becomes operative; the Effective Date is January 1, 2026.

1.17 Employee

For purposes of this Plan only, the term Employee means a common law employee of the Employer.

The term *Employee* includes, but is not limited to, a person who is:

A. a leased employee, as defined in Code section 414(n),

B. a nonresident alien who receives no earned income (within the meaning of Code section 911(d)(2)) from an Employer that constitutes income from sources within the United States, as defined in Code section 861(a)(3), or

C. a collective bargained employee.

The term *Employee* does not mean:

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

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

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

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

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

1.18 Employer

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

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

1.19 ERISA

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

1.20 FMLA

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

1.21 Health Care Spending Account Plan

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

1.22 Health Savings Account

Health Savings Account means an account established by a Covered Employee pursuant to section 223 of the Code who participates in a Company-sponsored high deductible health plan.

1.23 HIPAA

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

1.24 Hours of Service

Hours of Service means an hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer, or for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence, solely to the extent required by Treas. Reg. §54.4980H-1(a)(24). Hours of Service for salaried employees and hourly employees are based on actual hours worked.

1.25 Incorporated Document

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

1.26 Initial Administrative Period

Initial Administrative Period means the period beginning no longer than a month and a fraction of a month after the end of the Initial Measurement Period and ending immediately before the start of the Initial Stability Period. The Initial Administrative Period also includes the period between a new Employee's hire date and the beginning of the Initial

Measurement Period, to the extent that the Initial Measurement Period does not begin on the new Employee's date of hire.

1.27 Initial Measurement Period

Initial Measurement Period means the period beginning on the first of the month following the Employee's start date and ending 12 months later. The Employer shall measure the Employee's Hours of Service during the Initial Measurement Period as prescribed by Treas. Reg. §54.4890H-3(d)(3).

1.28 Initial Stability Period

Initial Stability Period means the period of time beginning immediately after the Initial Administrative Period, and ending twelve (12) months later.

1.29 New Full-time Employee

New Full-time Employee means a new Employee who, at the time of hour, is regularly scheduled to work on average at least 30 Hours of Service per week during the Initial Measurement Period, other than a Seasonal Employee.

1.30 New Part-time Employee

New Part-time Employee means a new Employee who, at the time of hire, is not regularly scheduled to work on average at least 30 Hours of Service per week during the Initial Measurement Period.

1.31 Participating Employer

Participating Employer means an Employer that was a participating employer in the Plan as of the Effective Date or that is an affiliate of the Company and has elected to participate in this Plan after the Effective Date with the consent of the Plan Administrator.

1.32 Plan

Plan means the Magna International of America, Inc. Welfare Benefit Plan as herein set forth and as amended from time to time.

1.33 Plan Administrator

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

1.34 Plan Year

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

1.35 Retiree

Retiree for purposes of the Retiree Premium Reimbursement Plan means an employee who retired before August 1, 2009, was at least age 60, and had at least 10 years of service with a Participating Employer.

1.36 Retiree Premium Reimbursement Plan

Retiree Premium Reimbursement Plan means the health reimbursement arrangement for eligible Retirees described in the Plan's summary plan description.

1.37 Salary Deduction Agreement

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

1.38 Salary Deduction Contributions

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

1.39 Salary Reduction Agreement

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

1.40 Salary Reduction Contributions

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

1.41 Seasonal Employee

Seasonal Employee means an Employee who is hired into a position for which the Employer determines that the customary annual employment is six months or less and at approximately the same time each year.

1.42 Spouse

Spouse means, for purposes of this Plan only, the Covered Employee's legal spouse, including a same-sex spouse and a common law spouse.

1.43 Standard Administrative Period

Standard Administrative Period means the period (of no longer than 90 days) beginning immediately after the end of the Standard Measurement Period and ending immediately before the start of the Standard Stability Period.

1.44 Standard Measurement Period

Standard Measurement Period means the 12 month period ending on the October 13th prior to the Plan Year beginning on January 1st. The Employer shall measure the Employee's Hours of Service during the Standard Measurement Period as prescribed by Treas. Reg. §54.4980H-3(d)(1).

1.45 Standard Stability Period

Standard Stability Period means the Plan Year immediately following the end of a Standard Measurement Period and Standard Administrative Period.

1.46 Variable Hour Employee

Variable Hour Employee means a new Employee if, based on the facts and circumstances at the Employee's start date, the Employer cannot reasonably determine whether the Employee will average at least 30 Hours of Service per week over the Initial Measurement Period because the Employee's hours are variable or otherwise uncertain. Interns and co-op students are classified as Variable Hour Employees.

ARTICLE III

ELIGIBILITY, PARTICIPATION AND COVERAGE

1.47 Eligibility

A. An Employee shall become eligible for Plan participation on the later of the Effective Date or the date specified under the Incorporated Document or location-specific supplement specifying the date on which an Employee is eligible to enroll. A Retiree is only eligible for the Retiree Premium Reimbursement Plan as described in the plan's summary plan description.

B. Eligibility for Medical/Prescription Drug Benefits.

1. An Employee shall be eligible for Plan participation in the Medical and Prescription Drug benefits described in Section 4.4(A) as follows:

a. Any Employee who is regularly scheduled to work least 30 Hours of Service per week is deemed to be a Full-Time Employee and is eligible for Medical/Prescription Drug Benefits.

Any other Employee is eligible only if he or she works, on average, 30 or more hours per week during an Initial Measurement Period or Standard Measurement Period, as applicable.

b. For an Employee who has not worked an entire Standard Measurement Period,

(1) If the Employee is classified by the Employer as a New Full-time Employee, effective September 1, 2022, the Employee will be eligible for coverage within 30 days following his or her date of hire.

(2) If the Employee is classified by the Employer as a Variable Hour Employee, New Part-Time Employee, or Seasonal Employee, and if the Employee averages at least 30 Hours of Service per week during the Initial Measurement Period, the first day of the Initial Stability Period shall be no later than the first of the month following 13 consecutive months after the Employee's date of hire. However, if the Employee experiences a change in employment status during the Initial Measurement Period such that, had the Employee begun employment in the new position or status, the Employee would have been expected to work at least 30 Hours of Service per week (and would not have been a Seasonal Employee), the Employee will be immediately eligible for Medical benefits if the Employee has satisfied the waiting period.

The Employer intends to use the methodology set forth in Treas. Reg. §54-4980H-3(d) for determining whether a Part-Time, Variable Hour or Seasonal Employee is a full-time employee for purposes of eligibility for Medical/Prescription Drug Benefits under this Plan.

2. Notwithstanding any other Plan provision, the following Employees are not eligible to participate in the Medical/Prescription Drug benefits offered by the Plan under Section 4.4(A):

   a. New Part-time, Variable Hour or Seasonal Employees who have not averaged at least 30 Hours of Service per week during an Initial Measurement Period or Standard Measurement Period, as applicable, will not be eligible for the Medical/Prescription Drug benefits during the immediately subsequent Initial Stability Period or Standard Stability Period, as applicable.

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

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

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

3. To the extent that these eligibility rules in Section 3.1(A) do not address a specific eligibility issue, Employer shall have discretion to make eligibility determinations consistent with applicable law and regulations, including special rules for changes in employment status, special unpaid leaves of absence and international transfers in Treas. Reg. §54.4980H.

4. An Employee who is eligible for Medical and Prescription Drug Benefits and who enrolls in a Company-sponsored high deductible health plan may make Salary Reduction Contributions to a Health Savings Account.

C. Eligibility for Benefits other than Medical/Prescription Drug Benefits.

1. An Employee shall become eligible for Plan participation in the benefits identified in Article IV other than Medical/Prescription Drug Benefits on the later of the Effective Date or the date specified under the Incorporated Document or location-specific supplement specifying the date on which an Employee is eligible to enroll.

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

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

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

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

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

D. Special Rules

1. A Covered Employee who is re-hired as a Full-Time Employee within six months after his or her date of termination is not required to satisfy a new waiting period.

2. A Full-Time Employee is not subject to a waiting period if he or she was hired by an affiliate of the Company outside of the United States and is transferred to a United States location of a Participating Employer.

3. Continuous active service with one Participating Employer is counted as like service with a subsequent Participating Employer, if the later service begins within 30 days after the earlier service ends.

4. Eligible Employees who reside in Canada, but work in the United States and are paid through U.S. payroll, have the option to enroll in the U.S. health care plan (medical, prescription drug, dental and vision) and enroll their Spouse and Dependents in the Canadian plan for extended heath care and dental. This option is available to Employees provided the Participating Employer by whom they are employed has at least three employees enrolled in this program. If an Employee is eligible for and elects this option, the Employee's pre-tax contributions will be determined by the level of coverage he/she selects (employee only, two person or family.) All deductions will be made in U.S. dollars.

5. If an Employee and the Employee's Spouse both work for the same or a different Participating Employer, the Employee may enroll his/her Spouse as a covered Dependent under the Employee's coverage and the Spouse would waive their coverage

6. If a Spouse is eligible for medical coverage through his or her non-Magna employer, the Spouse must enroll in his or her employer's medical plan in order to be eligible for Medical coverage under this Plan. This rule does not apply if a Spouse's medical coverage is unaffordable. Affordability for this purpose is based on the amount that the Spouse is required to contribute toward the cost of coverage under his or her employer's lowest cost, single coverage plan. If the Spouse's annual contribution is greater than 50% of the total cost of the lowest-cost Medical option under this Plan, the Spouse may waive coverage under his or her employer's plan and enroll in the Medical coverage under this Plan. However, if the Spouse's annual contribution is equal to or less than 50% of the total cost of the lowest-cost Medical option under this Plan, the Spouse must enroll in his or her employer's plan in order to enroll in the Medical coverage under this Plan. This rule affects the Spouse only – eligible children can be enrolled either in this Plan or in the Spouse's employer's medical plan coverage.

   This rule also does not apply if the Spouse is only eligible for a limited health plan from his or her non-Magna employer. A limited health plan means:

   a. A short-term limited duration plan;
   b. A plan intended to supplement comprehensive major medical coverage, such as an accident insurance or hospital indemnity plan;
   c. A plan that provides a payment for a specified illness, such as cancer or a heart attack; or
   d. An excepted benefit plan, such as a standalone dental or vision plan or a health flexible spending account.

1.48 Participation

Employees become Plan participants with respect to non-elective Benefits set forth in Section 4.5 on the date they satisfy the eligibility requirements of Section 3.1. Employees become Plan participants with respect to elective Benefits set forth in Section 4.4 on the date they also satisfy the enrollment and election requirements of Section 5.4 or 5.5. Retirees become Plan participants with respect to the Retiree Premium Reimbursement Plan as described in the plan’s summary plan description.

1.49 Coverage

A. Date Coverage Begins

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

B. Coverage During Leave of Absence

1. Paid Leave

During an approved paid leave of absence, a Covered Employee continues to participate in all benefits.

2. Unpaid Leave

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

Except as otherwise provided below, for Plan benefits requiring an Employee contribution, coverage for a Covered Employee on an approved unpaid leave of absence or layoff will continue and your contributions will be suspended for up to 30 days. Upon return from leave, the Employee will be reinstated to the full annual election amount, with the Salary Reduction Contribution adjusted accordingly for the balance of the Plan Year.

If an Employee is on approved leave of absence (other than a leave taken pursuant to FMLA) or is laid off and does not return to work within 30 days, coverage will end on the 31st day after the leave or layoff began, except pursuant to Article VII.

To the extent the Covered Employee may continue coverage during an unpaid leave, and except as required below, the Covered Employee is required to pay for coverage on an after-tax basis.

If the unpaid leave of absence is taken pursuant to FMLA, Covered Employees may elect to continue participation in premium payment benefits described in Sections 4.4(A), (B), (C) and (D) by (i) pre-paying on a before-tax basis the premiums for coverage during the leave, (ii) paying for premium payment benefits during the FMLA leave on an after-tax basis, or to the extent possible on a before-tax basis, or (iii) paying on a before-tax basis upon return from the leave the premium payment benefits for coverage during the leave, and adjusting the Salary Reduction Contribution accordingly for the balance of the Plan Year.

With respect to premium payment benefits described in Section 4.4(D), if the Covered Employee elects to revoke such coverage during the unpaid leave, no expenses incurred during the leave shall be reimbursed. Upon return from leave, the Employee can either: i) elect to be reinstated in the prior election amount, reduced by the dollar amount of the annual election not contributed during the unpaid leave, or ii) elect to be reinstated to the full annual election amount, with the Salary Reduction Contribution adjusted accordingly for the balance of the Plan Year.

With respect to premium payments benefits described in Sections 4.4(E), (F), (G), (H) and (I), an Employee may elect to continue participation by paying premium payment benefits during the FMLA leave on an after-tax basis.

Notwithstanding the foregoing, if an Employee returns to work after an unpaid leave of absence without a Break in Service, the Employee will be eligible for Medical/Prescription Drug benefits upon return if the Employee returns during an Initial Stability Period or Standard Stability Period in which the Employee is eligible for Medical/Prescription Drug benefits under Section 3.1(B). If the Employee returns to work after a Break in Service, the Employee will be treated as an Employee who has not worked an entire Standard Measurement Period under Section 3.1(B) to the extent permissible by law.

3. Special Rule for Disability Leave

a. Disability Leave Beginning on or after January 1, 2025.

If the Covered Employee begins an approved disability leave on or after January 1, 2025 due to disease, injury or pregnancy, the Covered Employee must continue to make his/her contributions for Medical, Dental and Vision coverage for the first twelve months of the disability leave (six months of Short-Term Disability and the first six months of Long-Term Disability). Employer-subsidized Medical, Dental and Vision coverage will continue until the first to occur of (i) 12 months from the date the disability leave commenced; (ii) the date the Covered Employee is no longer disabled under the terms of the Short-Term Disability or Core Long-Term Disability Plan; or (iii) the date the Covered Employee qualifies for Medicare due to age, disability or on any other basis. The first six months of Employer-subsidized coverage will run concurrent with Short-Term Disability leave. At the beginning of the leave, the Plan Administrator will notify the Covered Employee whether his/her contributions will be made via payroll or through a separate payment arrangement. At the end of the 6-month period of Employer-subsidized coverage that runs concurrent with Short-Term Disability, the Covered Employee will be offered the opportunity to enroll in COBRA continuation coverage. The last six months of Employer-subsidized coverage would continue after the Covered Employee qualifies for Long-Term Disability benefits and elects COBRA, and this period will run concurrently with COBRA continuation coverage. At the end of the 12-month period of Employer-subsidized coverage, the Covered Employee will still be eligible to continue COBRA continuation coverage for the remaining months in the maximum coverage period at 102% of the cost of coverage.

If at any point during the 12-month period of the subsidized coverage, the Covered Employee is no longer disabled i.e. no longer approved for short or

long-term disability and does not return to work at the end of the leave, the Covered Employee will be offered the opportunity to elect or continue COBRA continuation coverage at his/her cost for any months remaining in the maximum coverage period.

The maximum coverage period for purposes of COBRA continuation coverage begins on the date the Covered Employee qualifies for Long-Term Disability benefits, or the end of Short-Term Disability leave if the Covered Employee does not qualify for Long-Term Disability benefits. If the Covered Employee were to die or become eligible for Medicare before the end of the 12-month period of Employer-subsidized coverage, coverage for the Covered Employee's dependents will end and they may be offered COBRA continuation coverage.

The Covered Employee may enroll in a different Medical coverage option during the open enrollment period; however, if the Covered Employee enrolls for coverage that provides richer benefits, the Covered Employee will be required to pay any related increase in cost during the 12-month period of Employer-subsidized coverage.

The Covered Employee must also continue to make contributions for any voluntary benefits that the Covered Employee wishes to maintain during the leave, such as voluntary life insurance or buy-up disability. These benefits will remain in effect until the Covered Employee's termination of employment, as long as the Covered Employee timely makes the contributions. During the first six months of the leave, the Plan Administrator will notify the Covered Employee whether contributions will be made via payroll or through a separate payment arrangement. After the initial six-month period, the Covered Employee should contact the Plan Administrator to make payment arrangements.

Employees covered by a collective bargaining agreement may be subject to different rules regarding continuation of coverage during a disability leave as described in the applicable collective bargaining agreement.

b. Disability Leave Beginning Before January 1, 2025.

If the Covered Employee begins an approved disability leave due to disease, injury or pregnancy, Medical, Dental and Vision coverage may continue for a maximum of 29 months. The Covered Employee must continue to make contributions for Medical, Dental and Vision coverage for the first six months of the disability leave. If the Covered Employee then qualifies for Long-Term Disability benefits, contributions for Medical, Dental and Vision coverage for the Covered Employee and his/her eligible Dependents are waived for the coverage options in which the Covered Employee is enrolled as of the date of disability for the remainder of the 29-month period. Medical, Dental and Vision coverage will continue until the

first to occur of 29 months from the date the disability leave commenced; the date the Covered Employee is no longer disabled under the terms of the Short-Term Disability or Core Long-Term Disability Plan; the date the Covered Employee qualifies for Medicare due to age, disability or on any other basis; or the end of the maximum coverage period available to the Covered Employee under COBRA continuation coverage. The 29-month period of extended coverage runs concurrently with COBRA continuation coverage described in Article VII. If the Covered Employee is no longer disabled and does not return to work at the end of the leave, the Covered Employee will be offered the opportunity to elect COBRA continuation coverage for any months remaining in the maximum coverage period. The maximum coverage period begins:

i. On the first day after an FMLA leave ends, if the disability leave qualifies as an FMLA leave, or

ii. On the first day of a disability leave, if the disability leave does not qualify as an FMLA leave.

If the Covered Employee were to die or become eligible for Medicare before the end of the 29-month period, coverage for his/her Dependents will end and they may be offered COBRA continuation coverage as described in Article VII.

The Covered Employee may enroll in a different Medical coverage option during the open enrollment period; however, if the Covered Employee enrolls for coverage that provides richer benefits, the Covered Employee will be required to pay any related increase in cost during the 29-month period.

Covered Employees covered by a collective bargaining agreement may be subject to different rules regarding continuation of coverage during a disability leave as described in the applicable collective bargaining agreement.

C. Date Coverage Ceases

Except as otherwise provided in Article VII, coverage for a specific benefit offered under the Plan ceases on the earliest of:

1. the date of termination of employment,

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

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

4. the date on which coverage is cancelled in accordance with Section 5.8; or

5. the date the Plan terminates.

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

1. on the date the Dependent is no longer eligible due to a divorce or, if an Incorporated Document requires a child to be a full-time student, the Dependent is no longer a full-time student;

2. on the date on which the dependent is no longer an eligible Dependent due to reaching the limiting age specified in an Incorporated Document;

3. on the date on which coverage for the Dependent is cancelled in accordance with Section 5.8; or

4. for a Dependent child who is covered by the Plan under the terms of a Qualified Medical Child Support Order, on the date coverage ends according to the terms of the Qualified Medical Child Support Order.

D. Effect of Terminated Coverage

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

E. Reinstatement of Coverage

1. If Previously Suspended

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

Notwithstanding the foregoing, if an Employee returns to work without a Break in Service, the Employee will be eligible for Medical/Prescription Drug benefits upon return if the Employee returns during an Initial Stability Period or Standard Stability Period in which the Employee is eligible for Medical/Prescription Drug benefits under Section 3.1(B). If the Employee returns to work after a Break in Service, the Employee will be treated as an Employee who has not worked an entire Standard Measurement Period under Section 3.1(B) to the extent permissible by law.

2. If Previously Terminated

A Covered Employee who returns to an Employer's service shall be eligible to participate in the Plan and make new benefit elections, provided such Employee satisfies the eligibility requirements of Section 3.1. Notwithstanding the foregoing, if a former Covered Employee returns to service during the same Plan Year and within 30 days of the date prior participation ended, his or her elections for Benefits described in Sections 4.4(A), (B), (C), (D) and (E) shall be reinstated for the remainder of the Plan Year, except as described in Section 5.8. The above rule shall not apply and the rehired Employee shall be eligible to make new elections for Benefits described in Sections 4.4(A), (B), (C), (D) and (E) for the balance of the Plan Year, if it is determined to the satisfaction of the Plan Administrator that the prior termination of employment and reinstatement was bona fide and not an attempt to avoid the irrevocable rule described in Section 5.8(A).

Notwithstanding the foregoing, if an Employee returns to work without a Break in Service, the Employee will be eligible for Medical/Prescription Drug benefits upon return if the Employee returns during an Initial Stability Period or Standard Stability Period in which the Employee is eligible for Medical/Prescription Drug benefits under Section 3.1(B). If the Employee returns to work after a Break in Service, the Employee will be treated as an Employee who has not worked an entire Standard Measurement Period under Section 3.1(B) to the extent permissible by law.

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

A. Family and Medical Leave Act of 1993

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

B. Section 609 of ERISA

If not otherwise provided for herein, the Plan shall provide coverage to a child solely to the extent required by a qualified medical child support order defined

under section 609(a) of ERISA or to an adoptive child or child placed for adoption solely to the extent required by section 609(c) of ERISA. Further, the Plan shall be interpreted and administered as necessary to comply with section 609 of ERISA and the rulings and regulations issued thereunder.

C. Coverage Contingent Upon Contribution

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

1.51 Uniformed Services Employment and Reemployment Rights Act

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

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

1.52 Health Insurance Portability and Accountability Act of 1996

A. HIPAA Title I

Solely to the extent required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), an Employee shall be a Covered Person under the Plan no later than such time as required under HIPAA, and the Plan shall be subject to the special enrollment and nondiscrimination in health status provisions of HIPAA. This Section 3.6 shall be interpreted and applied to give a Covered Person only those rights as prescribed under HIPAA and the rulings and regulations issued thereunder.

B. HIPAA Title II

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

1.53 Coordination with State Medicaid Program

The fact that a Covered Person is eligible for coverage by, or is covered by, a State Medicaid program shall not affect the Covered Person's eligibility to participate in the Plan or to receive benefits. The payment of benefits under the Plan with respect to any Covered Person shall be made in accordance with any assignment of rights made by or on behalf of the Covered Person or a beneficiary of the Covered Person as required by any State Medicaid program, as provided in Section 609(b) of ERISA. To the extent a payment has been made to or with respect to a Covered Person pursuant to a State Medicaid program

and the amount so paid is for a medical expense that the Plan has a legal liability to pay, the Plan will pay such expense in accordance with any State law that provides that the State has acquired the right with respect to the Covered Person to receive payment for such expense.

1.54 Mental Health Parity Act and Mental Health Parity and Addiction Equity Act

Solely to the extent required by the Mental Health Parity Act and the Mental Health Parity and Addiction Equity Act of 2008, and as further amended by the Consolidated Appropriations Act, 2021, the Plan shall provide mental health benefits to the same extent as other medical benefits.

This Section 3.8 shall be interpreted and applied to give Covered Persons only those rights as prescribed under the Mental Health Parity Act and the Mental Health Parity and Addiction Equity Act, as amended by the Consolidated Appropriation Act, 2021, and the rulings and regulations issued thereunder.

1.55 Women's Health and Cancer Rights Act

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

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

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

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

1.56 Newborns' and Mothers' Health Protection Act

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

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

1.57 Genetic Information Nondiscrimination Act of 2008

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

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

1.58 Children's Health Insurance Program Reauthorization Act of 2009

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

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

1.59 Affordable Care Act

The Plan shall comply with the applicable provisions of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act and subsequent legislation (collectively, the "Affordable Care Act" or the "ACA").

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

The Company is hereby designated as the "plan sponsor" for purposes of the Patient-Centered Outcomes Research Institute fee under Code Section 4376 and, by its signature, the Company consents to this designation. Further, all self-insured health plans with the same plan year sponsored by the Company and not otherwise exempt are treated as a single applicable self-insured health plan for purposes of calculating the fee imposed by Code Section 4376.

3.14 Michelle's Law

Solely to the extent required by Michelle's Act, the Plan shall not terminate coverage of a dependent child due to a medically necessary leave of absence that causes the child to lose student status before the date that is the earlier of the date that is one year after the first day of the medically necessary leave of absence; or the date on which such coverage would otherwise terminate under the terms of the Plan.

This Section 3.14 shall be interpreted and applied to give Covered Persons only those rights as prescribed under Michelle's Law, and the rulings and regulations issued thereunder.

3.15 Consolidated Appropriations Act

The Plan shall comply with the applicable provisions of the Consolidated Appropriations Act, 2021 (the "CAA"), including the No Surprises Act and the transparency provisions applicable to health care.

This Section 3.15 shall be interpreted and applied to give Covered Persons only those rights as prescribed under the CAA, and the rulings and regulations issued thereunder.

3.16 Participating Employers

With the consent of the Plan Administrator, employers who are affiliates of the Company may become Participating Employers. In that event, their eligible Employees will be Covered Employees in the Plan when they satisfy the Plan coverage requirements. Terms and conditions of the Plan as applicable to such Employees of new Participating Employers shall be set forth in the applicable Incorporated Document. The Plan Administrator shall maintain a current list of Participating Employers in the Plan.

Any Participating Employer may withdraw from the Plan by giving notice in writing of the withdrawal to the Plan Administrator at least 30 days in advance.

ARTICLE IV

BENEFITS

1.60 Benefits

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

1.61 Options

Covered Employees must elect one of the following:

A. to receive the full unreduced compensation benefit described in Section 4.3, and receive automatic coverage under Benefits described in Section 4.5; or

B. to forego all or part of the unreduced compensation benefit described in Section 4.3 and make before- or after-tax contributions in exchange for one or a combination of Benefits described in Section 4.4 and receive automatic coverage under Benefits described in Section 4.5.

Employee contributions for Benefits described in Sections 4.4(A), (B), (C), (D), and (E) must be made on an entirely before-tax basis through a Salary Reduction Agreement. Employee contributions for Benefits described in Sections 4.4(F), (G), (H) and (I) may be made only on an after-tax basis through a Salary Deduction Agreement. There are no Employee Contributions for Benefits described in Sections 4.5(A), (B), (C), (D), (E) and (F).

1.62 Unreduced Compensation Benefit

In lieu of all or some of the Benefits described in Section 4.4 that a Covered Employee otherwise could elect, he or she may elect to receive unreduced compensation in an amount equal to the value of the Benefits available for election that are not elected. The unreduced compensation benefit is subject to the Employer's regular payroll practices; applicable local, state, and federal income tax withholding; and other applicable deductions. The unreduced compensation benefit is not additional compensation; it is the amount by which a Covered Employee's compensation is not reduced each pay period by failing to elect a premium payment benefit. The unreduced compensation benefit shall cease whenever the Covered Employee commences an unpaid leave of absence, terminates employment, or the Covered Employee's Employer determines, in its sole discretion, that compensation is not payable to such Employee.

1.63 Elective Benefits

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

A. Medical/Prescription Drug Premium Payment Benefit

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

If an Employee is eligible for medical benefits, he or she may elect any of the medical plan options as the medical premium payment benefit. If an Employee enrolls for medical benefits, the Employee will be automatically enrolled in the corresponding level of prescription drug coverage.

B. Dental Premium Payment Benefit

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

C. Vision Premium Payment Benefit

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

D. Health Care Spending Account Premium Payment Benefit

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

If an Employee is eligible for the health care spending account benefits, he or she may elect any whole dollar annual contribution amount of not more than $2,500, or if more, the maximum amount allowed under Section 125(i) of the Code, as the health care spending account premium payment benefit.

E. Dependent Care Spending Account Premium Payment Benefit

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

If an Employee is eligible for dependent care spending account benefits, he or she may elect any whole dollar annual contribution amount of not more than $7,500 as the dependent care spending account premium payment benefit, or such lesser amount set forth in the Incorporated Document.

F. Buy-Up Long-Term Disability Premium Payment Benefit

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

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

G. Supplemental Life Premium Payment Benefit

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

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

H. Supplemental Dependent Life Premium Payment Benefits

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

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

I. Supplemental AD&D Premium Payment Benefit

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

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

J. Health Savings Account

Employees who are Covered Persons and who are enrolled in a Company-sponsored high deductible health plan (as defined in Section 223(c)(2) of the Code) may make Salary Reduction Contributions to a Health Savings Account, up to the annual contribution limit permitted by section 223(b) of the Code.

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

1.64 Non-Elective Benefits

A. Basic Life Benefits/Basic Dependent Life Benefits

Employees who are Covered Persons shall have the right to the basic life/basic dependent life benefits provided under the applicable Incorporated Documents.

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

B. Basic AD&D Benefits

Employees who are Covered Persons shall have the right to the basic AD&D benefits provided under the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations, and exclusions shall be set forth in the applicable Incorporated Documents.

C. Employee Family Assistance Benefits

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

D. Core Short-Term Disability Benefits

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

E. Core Long-Term Disability Benefits

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

F. Business Travel Accident Benefits

Employees who are Covered Persons shall have the right to the business travel accident benefits provided under the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such

Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations, and exclusions shall be set forth in the applicable Incorporated Documents.

1.65 Limits for Certain Employees

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

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

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

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

1.66 Notification of Premium Payment Amounts

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

1.67 Application of Other Plans

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

4.9 Retiree Premium Reimbursement Plan

Retirees (as defined in Section 2.31) may elect to participate in the Retiree Premium Reimbursement Plan. This plan is a "health reimbursement arrangement" maintained by the Company for eligible Retirees, which reimburses a portion of a Retiree's eligible

premium expenses. The benefits under this Plan shall be subject to the terms, conditions, and limitations set forth in the applicable Incorporated Document. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations, and exclusions shall be set forth in the applicable Incorporated Document. Retirees who participate in the Retiree Premium Reimbursement Plan do not participate in the Cafeteria Plan and do not make Salary Reduction Contributions or Salary Deduct on Contributions to the plan.

ARTICLE V

ELECTIONS

1.68 Enrollment for Non-Elective Benefits

All Employees meeting the eligibility requirements of Section 3.1 shall be automatically covered for Benefits described in Section 4.5 and such benefits shall not be subject to the provisions of this Article V.

1.69 Enrollment for Elective Benefits

A. Initial Enrollment/Election

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

B. Annual Enrollment/Election

Approximately 30 to 60 days before each Plan Year begins, the Plan Administrator shall conduct an enrollment during which Employees may make new elections or change existing elections for the next Plan Year.

C. Retirees

Retirees enroll in the Retiree Premium Reimbursement Plan as described in the plan's summary plan description.

1.70 Salary Reduction/Deduction Agreements

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

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

1.71 Forms and Agreements

Employees may enroll, make elections, and direct their Employer to make Salary Reduction Contributions and/or Salary Deduction Contributions only by filing the

appropriate, completed forms or agreements (which may be in electronic form) with the Plan Administrator before the deadline described in Section 5.6.

1.72 Default Benefits

The Plan Administrator shall conduct an enrollment during which Employees may make new elections or change existing ones for the next Plan Year. Unless the Plan Administrator approves a supplemental election, as described in Section 5.8(B), a Covered Employee who fails to submit a valid enrollment/election and Salary Reduction Agreement and/or Salary Deduction Agreement, as required in Section 5.4, is deemed to have continued coverage in all elective benefits except the Health Care Spending Account Plan and the Dependent Care Spending Account Plan.

An Employee enrolling for the first time who fails to submit a valid enrollment/election and Salary Reduction Agreement and/or Salary Deduction Agreement, as required in Section 5.4, is deemed to have elected employee-only coverage in the lowest-cost option for the Medical/Prescription Drug Benefit plans.

Contributions required for the default coverage shall be deducted from the Employee's pay as Salary Reduction Contributions, as permitted under the Code, or as Salary Deduction Contributions.

1.73 Deadlines

A. Initial Enrollment/Election

For newly hired Employees who become eligible after the Effective Date but before the annual enrollment described in Section 5.2(B), the deadline for enrolling and making initial elections is the last day of the Employee's waiting period, or within a period of time of up to 30 days after the end of the waiting period (if allowed by the Participating Employer). Salary Reduction Agreements and/or Salary Deduction Agreements completed by Eligible Employees shall be effective as of the date on which the Employee becomes eligible in accordance with Section 3.1 and completes the initial enrollment agreement with the Plan Administrator.

B. Annual Enrollment/Election

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

1.74 Validity of Election Forms

A. Plan Administrator Approval

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

B. Remedial Modification or Rejection

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

1.75 Changing Elections

A. General Rule

All elections and Salary Reduction Agreements and/or Salary Deduction Agreements stay in force during the entire Plan Year to which they apply unless changed or revoked as provided in this Section 5.8. During annual enrollment, however, Covered Employees may make new benefit elections or change existing ones for the forthcoming Plan Year.

B. Supplemental Elections

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

C. Revocation of Elections

Except as provided in Section 3.3(B) or (C), Covered Employees may revoke elections (including default elections) and Salary Reduction Agreements and Salary Deduction Agreements during a Plan Year only in accordance with the provisions described in this Section 5.8(C). Except as provided in the next sentence, a Covered Employee must make the change within 31 days of the event giving rise to the election change. In the event of a HIPAA special enrollment due to the loss of Medicaid or a state children's health insurance program (CHIP) or initial

entitlement to state premium assistance by an Employee, Spouse or Dependent a Covered Employee will have 60 days from the date of the event to make an election change. Notwithstanding the provisions of this Section 5.8(C), an Employee's or Covered Employee's ability to elect or revoke any benefit option mid-year may be restricted by the terms of the Incorporated Document governing that benefit option. Additionally, a Covered Employee who is enrolled in a Health Savings Account may change his/her election prospectively as of the first day of any month if the change is consistent with section 223 of the Code.

1. Separation from Service

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

2. Change in Status

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

   Election and Salary Reduction Agreement changes must be consistent with the Change in Status, except for elections made pursuant to the special enrollment provisions of HIPAA.

   For purposes of this paragraph (2), the term "consistent" means that the Change in Status event must cause the Employee or Employee's Spouse or Dependent children to gain or lose eligibility under an employer-sponsored benefit offered through this Plan or the plan of the Spouse or Dependent, including a Change in Status that results in an increase or decrease in the number of an Employee's Dependents who may benefit from coverage under the Plan. The election shall take effect as soon as administratively practicable following the election change, but not earlier than the date of the Change in Status. With respect to an election made pursuant to marriage, a birth, adoption or placement for adoption of a child, the election change shall take effect as of the marriage, birth, adoption or placement for adoption.

   Notwithstanding the foregoing, a Covered Employee may not make any changes to the elective benefits set forth in Section 4.4(F), (G), (H), or (I), except that the Covered Employee can drop coverage upon termination of employment or if the Covered Employee or his/her Dependents become ineligible for benefits. The Covered Employee may also make changes to

Supplemental Dependent Life Insurance benefits as described in Section 4.4(H) for children following birth or adoption of a child or for a Spouse following marriage or divorce.

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

3. Cost Changes

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

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

The opportunity for making new elections under this paragraph (3) does not apply to the Health Care Spending Account Plan and applies to the Dependent Care Spending Account Plan only if a cost increase is imposed by a dependent care provider who is not a relative of the Covered Employee. For purposes of this subparagraph (c), a “relative” is an individual who is related as described in Code section 152(d)(2) (A) through (G), incorporating the rules of Code sections 152(f)(1)(B) and 152(f)(4).

4. Coverage Changes

a. Significant curtailment without a *loss of coverage*

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

b. Significant curtailment with *loss of coverage*

If coverage offered under the Plan is significantly curtailed to the extent that the Covered Employee experiences a *loss of coverage*,

affected Covered Employees may revoke their election and make a new election on a prospective basis for coverage under another option providing similar coverage, or may revoke existing coverage if no other option providing similar coverage is available. For purposes of this Section 5.8(C)(4), a *loss of coverage* means a complete loss of coverage under the benefit option and shall include the elimination of a benefit option, an HMO ceasing to be available where the individual resides, the individual losing all coverage under the option by reason of an overall lifetime or annual limitation, or other fundamental loss of coverage as determined by the Plan Administrator.

c. Addition or improvement of a benefit option

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

d. The opportunity for making new elections under this paragraph (4) does not apply to the Health Care Spending Account Plan.

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

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

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

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

The opportunity for making new elections under this paragraph (5) does not apply to the Health Care Spending Account Plan.

6. Loss of Coverage under Another Health Plan

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

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

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

c. A state health benefits risk pool, or

d. A foreign government group health plan.

The opportunity for making new elections under this paragraph (6) does not apply to the Health Care Spending Account Plan.

7. Automatic Adjustment of Election

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

ARTICLE VI

COORDINATION OF BENEFITS

1.76 Applicability

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

1.77 COB Definitions

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

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

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

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

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

5. Group or individual automobile no-fault coverage;

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

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

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

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

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

1.78 Order of Benefit Determination Rules

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

A. COB/Non-COB Provision

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

B. No Fault Auto Insurance

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

C. Non-Dependent/Dependent

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

D. Dependent Child/Parents not Separated or Divorced

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

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

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

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

E. Dependent Child/Separated or Divorced Parents

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

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

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

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

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

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

F. Active/Inactive Employee

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

G. Continuation Coverage

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

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

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

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

H. Longer-Shorter Length of Coverage

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

I. Medicare Coordination

1. Employees and/or Spouses Age 65 or Older

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

2. Medicare Disabled Covered Persons

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

3. Covered Persons with End-Stage Renal Disease

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

1.79 Effect on the Benefits of this Plan

A. When this Section Applies

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

B. Reduction in this Plan's Benefits

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

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

1.80 Limitation of Benefits

In applying this Article's provisions, the Plan does not pay health care benefits in an amount greater than it would have if it were primary.

1.81 Right to Receive and Release Necessary COB Information

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

1.82 Facility of Payment

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

1.83 Right of Recovery

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

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

B. insurance companies; or

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

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

1.84 Governing Provisions

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

ARTICLE VII

COBRA CONTINUATION COVERAGE

1.85 Eligibility for Continuation Coverage

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

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

1.86 Definitions

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

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

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

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

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

1. for Employees, termination of employment for any reason other than gross misconduct, or loss of eligibility due to reduction in hours worked by the Employee;

2. for Dependents:

a. death of the Employee;

b. divorce of the Employee and Spouse;

c. legal separation of the Employee and Spouse;

d. reduction in hours worked by the Employee or termination of employment by the Employee for any reason other than gross misconduct;

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

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

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

1.87 Loss of Eligibility for Continuation Coverage

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

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

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

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

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

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

1.88 Termination of COBRA Continuation Coverage

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

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

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

C. the date the Qualified Beneficiary first becomes, after the date of making a COBRA election, covered under another group health plan, as defined in Code section 5000(b)(1);

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

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

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

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

H. in the case of a Qualifying Event described in Section 7.2(D)(3), the date of death of the Employee or Qualified Beneficiary (described in Code section 4980B(g)(1)(D)(iii)), or in the case of a surviving spouse or Dependent children of the Employee, 36 months after the date of death of the Employee; or

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

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

1.89 Notice Requirements

A. The Employer shall notify the Plan Administrator of the occurrence of an event described in Sections 7.2(D)(1), 7.2(D)(2)(a), 7.2(D)(2)(d), and 7.2(D)(2)(e), and 7.2(D)(3) within 30 days of the date of the described event.

B. The Covered Employee or a Qualified Beneficiary shall be responsible for notifying the Plan Administrator of the occurrence of an event described in Sections 7.2(D)(2)(b), 7.2(D)(2)(c), or 7.2(D)(2)(f) within 60 days of the date of the described event, whether such event is an initial Qualifying Event or a second Qualifying Event.

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

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

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

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

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

1.90 Coverage Available for Continuation

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

1.91 Election Rules

A. Scope of Election

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

B. After Acquired Dependents

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

C. Open Enrollment Periods

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

D. Employer Paid Extended Coverage

Employer-paid coverage provided to an Employee who is on an approved disability leave described in Section 3.3(B)(3) shall run concurrently with COBRA continuation coverage. If the Employee is no longer disabled and does not return to work at the end of the leave, the Employee will be offered COBRA continuation coverage as described in Section 3.3(B)(3).

1.92 Required Premium

In order to receive COBRA continuation coverage, Qualified Beneficiaries shall agree, on forms furnished by the Plan Administrator, to pay any required premiums to the Plan and shall make such premium payments when and as required. All premiums other than the initial premium shall be due on the first day of the calendar month. The amount of the premium shall be no more than 102 percent of the cost of coverage. In the case of a Qualified Beneficiary who is determined under Title I or XVI of the Social Security Act to have been disabled at any time within the first 60 days of continuation coverage, the cost of coverage for the 19th month through the 29th month of coverage shall be no more than 150 percent of the cost of coverage. Notwithstanding the foregoing, the cost of coverage shall not exceed the maximum, nor be changed more frequently than, permitted by law.

1.93 Governing Provisions

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

ARTICLE VIII

CONTRIBUTIONS, FUNDING AND PLAN ASSETS

1.94 Contributions

A. Employer Contributions

The Employer shall make Employer contributions or pay premiums for Benefits listed in Section 4.4 to the Employer-sponsored plans to which such benefits are payable, provided that the Covered Employee shall authorize Salary Reduction Contributions in a corresponding amount pursuant to Section 8.1(B)(2).

The Employer shall make Employer contributions for benefits listed in Section 4.5 and Section 4.9 to the Employer-sponsored plans to which such benefits are payable.

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

B. Salary Reduction and/or Salary Deduction Contributions

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

1. not reduce their compensation and not provide premium payment benefits pursuant to Section 4.4, or

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

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

C. Priority of Contributions

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

D. COBRA Contributions

To the extent a former Covered Employee, Dependent or Spouse has exercised his or her continuation rights under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) with respect to benefits described in Sections 4.4(A), (B), (C), (D) and 4.5(C) the Plan shall accept contributions from such individuals as COBRA premiums.

1.95 Funding

A. Funding Policy

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

B. Funding Mechanism

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

1.96 Plan Assets

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

1.97 Treatment of Certain Policy Payments

Where an insurance policy or administrative services only contract ("ASO Contract") provides for payment of premiums or benefits directly from the Employer, unless the insurance policy or ASO Contract states otherwise, dividends, retroactive rate adjustments, rebates or experience refunds are not plan assets. Except as required by applicable law, these dividends, retroactive rate adjustments, rebates or experience refunds are Employer property, which the Employer may retain to the extent they do not exceed the Employer's aggregate contributions to Plan cost made from its own funds. Any Employee Family

Assistance Plan benefits offered under this Plan are not, and will not be, financed by another group health plan or any other benefit option within this Plan. In addition, all Employee Family Assistance Plan benefits and/or premiums will be paid solely from the general assets of the Employer, and will not be paid with Employee contributions.

ARTICLE IX

CLAIM AND PAYMENT PROCEDURES

1.98 General Claims Procedures

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

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

Solely with respect to the benefits described in Section 4.4(A), notwithstanding any other Plan provision to the contrary, the Plan intends to comply with Section 2719 of the Public Health Service Act, as set forth in the Affordable Care Act, and all regulations and guidance issued thereunder.

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

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

1.99 Claim Administrator

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

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

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

1.100 Claims Administration

The Claim Administrator shall have the duty to receive and review claims for benefits under the Plan; to determine what amount, if any, is due and payable under the terms and conditions of the Plan; to make or authorize appropriate disbursements of benefit payments to persons entitled thereto; to inform the Company or any other third party, as appropriate, of the amount of such benefits; to make claims decisions under the terms of the Plan; and to provide a full and fair review to any individual whose claim for benefits has been denied in whole or in part, except as described in Section 9.2 as applied to self-funded benefits.

1.101 Claimants

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

1.102 Claim Forms

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

1.103 Deadline for Filing a Claim

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

1.104 Proof of Claim

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

1.105 Decision on the Claim

The following rules shall apply to claims filed with respect to an ERISA Benefit under the Plan. Unless otherwise specified in an applicable Incorporated Document, these claim procedures will also apply to any non-ERISA Benefit under the Plan. An "adverse benefit determination" is a denial, reduction or termination of a benefit, failure to provide or pay for (in whole or in part) a benefit, a denial to participate in the Plan, or a claim adverse benefit determination on the grounds that the treatment is experimental, investigational or not medically necessary. This also includes concurrent care determinations. With respect to claims for medical benefits under Section 4.4(A) only, certain retroactive terminations of coverage under Section 4.4(A) will be considered adverse benefit determinations, whether or not there is an adverse effect on any particular benefit at that time, to the extent required

by the ACA, and as interpreted by applicable guidance and regulations from the relevant government agencies.

A. Benefits Other than Health and Disability Benefits.

Any time a claimant receives an adverse benefit determination for benefits, other than health and disability benefits as described in paragraphs B and C below, the claimant shall be given written notice of such action within a reasonable period of time but not later than 90 days after the claim is received by the plan, unless special circumstances require an extension of time for processing. If there is an extension, the claimant shall be notified of the extension and the reason for the extension within the initial 90-day period. The extension shall not exceed 180 days after the claim is filed.

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

a. the specific reason(s) for the adverse benefit determination;

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

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

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

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

B. Disability Benefits.

Any time a claimant receives an adverse benefit determination for disability benefits as described in Sections 4.4(F) and 4.5(D), the claimant shall be given written notice of such action within a reasonable period of time, no later than 45 days after the claim is received by the plan, unless the Claim Administrator determines that an extension of up to 30 days is necessary due to matters beyond the Plan's control. If there is an extension, the claimant shall be notified, before the initial 45-day period of time expires, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The 30-day extension period is tolled until the claimant responds to any information request. A second 30-day extension is also permitted if the Claim Administrator determines that, due to matters beyond the Plan's control, a decision cannot be rendered within the first extension period. In that case, the claimant shall be notified, before the end of the expiration of the first 30-day extension period, of the circumstances requiring

the extension and the date as of which the plan expects to render a decision. Such extension notices shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. The claimant shall be afforded at least 45 days within which to provide the specified information.

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

a. the specific reason(s) for the adverse benefit determination;

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

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

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

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

f. a discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views presented by the claimant to the disability plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the disability plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made by the Social Security Administration and presented by the claimant to the disability plan;

g. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the disability plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

h. either the specific internal rules, guidelines, protocols, standards or other similar criteria of the disability plan relied upon in making the adverse benefit determination, or alternatively, a statement that such

rules, guidelines, protocols, standards or other similar criteria of the disability plan do not exist; and

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

C. Health Benefits.

The following rules shall apply to medical, dental, vision, employee assistance plan and health care spending account benefits as described in Sections 4.4(A), (B), (C) and (D) and 4.5(C) and the Retiree Premium Reimbursement Plan described in Section 4.9, except that claims for benefits described in Sections 4.4(D) and 4.9 shall be considered "post-service" only.

1. Urgent Care Claims – Claims for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or, in the judgment of a physician, would subject the patient to severe pain that cannot be adequately managed otherwise. The Plan shall defer to an attending provider to determine if a medical claim under Section 4.4(A) is urgent.

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

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

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

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

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

   For non-urgent post-service health claims, the Plan has up to 30 days, to evaluate and process claims. The 30-day period begins on the date the claim is first filed. This period may be extended by 15 days provided the Claim Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the Plan and notifies the claimant within the initial period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. In addition, the notice of extension must include the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. The claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

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

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

5. Notification of Denial - applicable to all health claims

   In the event of an adverse benefit determination, the claimant will receive notice of the determination.

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

   a. the specific reason(s) for the adverse benefit determination;

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

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

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

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

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

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

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

For group health plan claims, the notice of adverse benefit determination shall include information sufficient to identify the claim involved, including

i. the date of service;

j. the health care provider;

k. the claim amount (if applicable); and

l. the denial code.

In addition, for group health plan claims, the notice of adverse benefit determination shall include the following information:

m. a statement that diagnosis and treatment codes (and their meanings) shall be provided upon request;

n. the denial code and its meaning, and a description of the Plan's standard used in denying the claim;

o. a description of the internal appeal and external review processes; and

p. the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes.

1.106 Right to Appeal

A claimant who has received an adverse benefit determination, shall have the right to appeal the adverse benefit determination.

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

A. Benefits Other than Health or Disability Benefits.

A claimant who has received an adverse benefit determination for benefits, other than the health and disability benefits as described in paragraphs B and C below, or is otherwise adversely affected by action of the Claim Administrator, shall have the right to request review of the claim. Such request must be in writing and must be made within 60 days after such claimant is advised of the Claim Administrator's action. The requested review must take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. If written request for review is not made within the 60-day period, the claimant shall forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all relevant information and submit issues, comments, documents, records, and other information in writing.

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

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

a. the specific reason(s) for the adverse benefit determination;

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

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

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

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

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

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

B. Disability Benefits.

A claimant who has received an adverse benefit determination for disability benefits as described in Sections 4.4(F) and 4.5(D) or is otherwise adversely affected by action of the Claim Administrator, shall have the right to request review of the claim. Such request must be in writing and must be made within 180 days after such claimant is advised of the Claim Administrator's action. If written request for review is not made within the 180-day period, the claimant shall forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all relevant information and submit issues and comments in writing.

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

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

a. the specific reason(s) for the adverse benefit determination;

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

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

d. a statement of the claimant's right to bring a civil action under section 502(a) of ERISA. The statement will describe any applicable contractual limitations period that applies to the claimant's right to bring an action, including the calendar date on which the contractual limitations period expires for the claim;

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

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

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

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

i. A discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views presented by the claimant to the disability plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the disability plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made by the Social Security Administration and presented by the claimant to the disability plan;

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

In deciding an appeal of any adverse benefit determination based in whole or in part on a medical judgment, the Plan Administrator or Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such individual shall not have been consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual. In deciding an appeal, no deference will be afforded to the initial adverse benefit determination and the review of the appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.

The Claims Administrator will ensure that all claims and internal appeals for disability benefits are handled impartially. The Claims Administrator shall ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support an adverse benefit determination of benefits. The Claims Administrator shall ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

Prior to deciding an appeal, the Claims Administrator must provide the claimant with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim.

In connection with an internal appeal of a disability claim, a claimant shall be able to review his or her file and present information as part of the review. Before making a benefit determination on review, the Claims Administrator shall provide the claimant with any new or additional evidence considered or generated by the Plan, as well as any new or additional rationale to be used in reaching the decision. The claimant shall be given this information in advance of the date on which the notice of final appeal decision is made to give such claimant a reasonable opportunity to respond.

For disability claims, if the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to the claim, the claimant is deemed to have exhausted the internal claims and appeals process and may bring an action under ERISA Section 502(a) before the Plan's internal appeals process has been completed. However, this shall not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of

information, or if the error does not reflect a pattern or practice of noncompliance. In that case, the claimant may resubmit the claim for internal review and the claimant may ask the Plan to explain why the error is minor and why it meets this exception.

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

C. Health Benefits.

A claimant who has received an adverse benefit determination for medical, dental, vision, employee assistance plan, health care spending account benefits as described in Sections 4.4(A), (B), (C), (D), and 4.5(C) or the Retiree Premium Reimbursement Plan as described in Section 4.9, or is otherwise adversely affected by action of the Claim Administrator, shall have the right to request review of the claim. Such request must be in writing and must be made within 180 days after such claimant is advised of the Claim Administrator's action. If written request for review is not made within the 180-day period, the claimant shall forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all relevant information and submit issues and comments in writing.

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

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

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

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

If the group health plan claim is an urgent health claim or a claim requiring an ongoing course of treatment, the claimant may begin an expedited external review, as described in Section 9.10, before the Plan's internal appeals process has been completed.

Group health plan coverage as described in Section 4.4(A) shall continue pending the outcome of an internal appeal.

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

a. the specific reason(s) for the adverse benefit determination;

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

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

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

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

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

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

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

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

For group health plan claims, the notice of adverse benefit determination shall include information sufficient to identify the claim involved, including

a. the date of service;

b. the health care provider;

c. the claim amount (if applicable); and

d. the denial code.

In addition, for group health plan claims, the notice of adverse benefit determination shall include the following information:

e. a statement that diagnosis and treatment codes (and their meanings) shall be provided upon request;

f. the denial code and its meaning, and a description of the Plan's standard used in denying the claim. In the case of a final adverse benefit determination, the description must include a discussion of the decision;

g. a description of the external review processes; and

h. the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes.

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

In deciding an appeal of any adverse benefit determination based in whole or in part on a medical judgment, the Plan Administrator or Claims Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such individual shall not have been consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual. In deciding an appeal, no deference shall be afforded to the initial adverse benefit determination and the review of the appeal shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.

The Claims Administrator will ensure that all claims and internal appeals for group health plan benefits are handled impartially. The Claims Administrator shall ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support an adverse benefit determination of benefits. The Claims Administrator shall ensure that health care professionals consulted are not chosen based on the

expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

Prior to deciding an appeal, the Claims Administrator must provide the claimant with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim.

In connection with an internal appeal of a group health plan claim, a claimant shall be able to review his or her file and present information as part of the review. Before making a benefit determination on review, the Claims Administrator shall provide the claimant with any new or additional evidence considered or generated by the Plan, as well as any new or additional rationale to be used in reaching the decision. The claimant shall be given this information in advance of the date on which the notice of final appeal decision is made to give such claimant a reasonable opportunity to respond.

For group health plan claims, if the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to the claim, the claimant is deemed to have exhausted the internal claims and appeals process and may request an expedited external review before the Plan's internal appeals process has been completed. However, this shall not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, the claimant may resubmit the claim for internal review and the claimant may ask the Plan to explain why the error is minor and why it meets this exception.

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

1.107 Right to an External Review of Claims

To the extent required by the ACA, and as interpreted by applicable guidance and regulations from the relevant government agencies, the following rules shall apply to claims filed for benefits under Section 4.4(A) of the Plan. This Section 9.10 shall not be interpreted to give claimants any rights to external review beyond what is expressly required under the ACA, and as interpreted by applicable guidance and regulations from the relevant government agencies. This Section 9.10 is not applicable to any other benefits offered under the Plan.

The claimant shall be entitled to request an external review of (i) a medical claim involving medical judgment, as determined by the external reviewer, (ii) an adverse benefit determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in ERISA Sections 716 and 717, or

(iii) a coverage rescission, provided the claimant request the external review within four (4) months of the date of receipt of an adverse benefit determination (or a final internal adverse benefit determination). If the claimant's request for an external review is determined eligible for such a review, an independent review organization shall review the Claims Administrator's decision and provide the claimant with a written determination, as described in the Incorporated Documents.

The external review decision is binding on the claimant and the Plan, except to the extent that other remedies are available under federal law.

The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that is not related to medical judgment, surprise billing or cost-sharing protections under ERISA Sections 716 and 717, or coverage rescission.

1.108 Legal Remedy

Before pursuing a legal remedy, a claimant shall first exhaust all claims, review, and appeals procedures required under the Plan. Any lawsuit a claimant brings for Plan benefits must be filed within 36 months of the date on which the claim is incurred under the Plan.

1.109 Third Party Liability Claims

A. This Section 9.12 shall govern with respect to Plan benefits for injuries or illnesses of Covered Persons related to a third party's actions or inactions. To the extent that conflicting subrogation or recovery provisions exist in an insurance contract which is an Incorporated Document, such provisions in the insurance contract shall govern.

B. Subrogation

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

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

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

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

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

C. Plan's Right of Recovery

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

D. Enforcement of Plan's Subrogation and Recovery Rights

Should it be necessary for the Plan to institute proceedings against the Covered Person for failure to reimburse the Plan or to otherwise honor the Plan's equitable interest in obtaining amounts described in this Section 9.12, the Covered Person shall be liable for the costs of collection relating to such failure, including reasonable attorney's fees.

The Plan shall have the right to offset future benefits to which a claimant (or a Covered Person through whom the claimant derives his or her claim) may be entitled, until the amount otherwise due the Plan under this Section 9.12, plus interest, has been received by the Plan.

The Plan's rights under this Section 9.12 shall be enforceable regardless of whether the third party admits liability for the injury or illness to a Covered Person, and shall remain enforceable against the heirs and estate of any Covered Person.

1.110 Payment Procedures

A. Payment of Claim

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

B. Facility of Payment

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

C. Forfeiture

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

ARTICLE X

ADMINISTRATION

1.111 Plan Administrator

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

1.112 Plan Administrator's Duties

The Plan Administrator shall:

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

B. maintain:

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

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

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

1. the Plan's availability and terms,

2. the premium payment benefits available for election,

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

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

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

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

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

1.113 Plan Administrator's Powers

Except as expressly limited or reserved in the Plan to the Company or an Employer, the Plan Administrator shall have the right to exercise, in a uniform and nondiscriminatory

manner, full discretion with respect to the administration, operation, and interpretation of the Plan. Without limiting the generality of the foregoing rights, the Plan Administrator shall have full power and discretionary authority to:

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

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

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

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

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

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

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

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

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

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

1.114 Finality of Decisions

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

1.115 Compensation and Bonding of Plan Administrator

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

1.116 Liability Insurance

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

1.117 Reserved Powers

The Company reserves the powers, among others:

A. to adopt the Plan;

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

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

ARTICLE XI

AMENDMENT, TERMINATION OR MERGER OF PLAN

1.118 Right to Amend the Plan

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

1.119 Right to Terminate or Merge the Plan

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

1.120 Effect of Amendment, Termination or Merger

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

ARTICLE XII

MISCELLANEOUS

1.121 No Employment Rights

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

1.122 Exclusive Rights

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

1.123 No Property Rights

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

1.124 No Assignment of Benefits

Except as provided in Section 9.13, benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void. Notwithstanding the foregoing, a Covered Person may direct, in writing, that benefits payable to him or her be paid instead to an institution in which he or she is or was hospitalized, to a provider of medical or dental services or supplies furnished or to be furnished to him or her, or to a person or entity that has provided or paid for, or agreed to provide or pay for, any benefits payable under the Plan. The Plan reserves the right to make payment directly to the Covered Person. No payment by the Plan pursuant to such direction and assignment shall be considered as recognition by the Plan of a duty or obligation to pay a provider of medical or dental services or supplies except to the extent the Plan actually chooses to do so.

1.125 Right to Offset Future Payments

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

1.126 Right to Recover Payments

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

1.127 Misrepresentation or Fraud

A Covered Person who receives benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator shall decide such matters on a case by case basis. An Employee may be asked to provide proof of eligibility for his or her Dependents. False or misrepresented eligibility information could cause both the Employee's and his or her Dependents' coverage to terminate irrevocably (retroactively to the extent permitted by law), and could be grounds for Employee discipline up to an including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

1.128 Legal Action

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

No action at law or in equity in any court or agency shall be brought to recover benefits under the Plan prior to the exhaustion of the claims and appeals procedures set forth in Article IX, nor shall an action be brought at all unless within 36 months after the date a claim is incurred under the Plan.

1.129 Governing Law

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

1.130 Governing Instrument

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

1.131 Savings Clause

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

1.132 Captions and Headings

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

1.133 Notices

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

1.134 Waiver

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

1.135 Parties' Reliance

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

1.136 Disclaimer

The Company makes no assertion or warranty about:

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

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

1.137 Expenses

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

1.138 Indemnification

The Employer, to the extent permitted by law, shall indemnify and hold harmless any employee, officer or shareholder of the Company or the Employer from and against all loss, damages, liability and reasonable costs and expenses incurred in carrying out his or her responsibilities under the Plan, unless due to the bad faith or willful misconduct of such person, provided that such individual's attorney's fees and any amount paid in settlement shall be approved by the Company. The foregoing rights to indemnification shall be in addition to such other rights as the individual may enjoy as a matter of law or by reason of insurance coverage of any kind. Rights granted hereunder shall be in addition to and not in lieu of any rights to indemnification to which the individual may be entitled pursuant to the Company's certificate of incorporation or bylaws.

1.139 Employees' Tax Obligations

A. Excludability Determination

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

B. Liability and Payment

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

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

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

ARTICLE XIII

HIPAA PRIVACY AND SECURITY

2.1 Scope

The provisions of this Article XIII shall apply to the medical, dental, vision, employee assistance plan, the health care spending account and the Retiree Premium Reimbursement Plan.

2.2 Definitions

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

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

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

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

physical or mental health or condition of a person, the provision of health care to a person; or the past, present or future payment for health care.

2.3 Uses and Disclosures of PHI

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

2.4 Privacy Agreements of the Employer

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

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

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

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

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

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

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

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

H. If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or

destruction is not feasible, the Employer agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

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

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

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

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

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

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

2. the circumstances surrounding the Breach;

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

4. the information Breached;

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

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

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

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

Notwithstanding the foregoing, the terms of this Article XIII shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504(f)(1)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations.

2.5 Security Agreements of the Employer

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

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

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

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

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

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

APPENDIX A

MAGNA INTERNATIONAL OF AMERICA, INC.

DEPENDENT CARE SPENDING ACCOUNT PLAN

ARTICLE I

PLAN ESTABLISHMENT

1.1 Effective Date

The Magna International of America, Inc. Dependent Care Spending Account Plan ("the Plan") is amended and restated effective January 1, 2026.

1.2 Purpose

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

1.3 Qualification

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

1.4 Incorporation By Reference

The term "Cafeteria Plan" as used in this Plan means the Magna International of America, Inc. Cafeteria Plan as defined in Section 1.3 of the Magna International of America, Inc. Welfare Benefit Plan. The terms of the Cafeteria Plan are incorporated by reference wherever they apply to this Plan's operation to the extent such provisions do not conflict with the terms of this Plan.

1.5 Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Company, in its sole discretion, may amend or terminate the Plan or any provision of the Plan at any time.

ARTICLE II

DEFINITIONS

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

2.6 Covered Employee

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

2.7 Dependent Care Expenses

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

2.8 Dependent Care Spending Account Plan

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

2.9 Effective Date

Effective Date means the date the amended and restated Plan becomes operative; the Effective Date is January 1, 2026. The original effective date of the Plan was January 1, 2006.

2.10 Exclusions

Exclusions means the exclusions in Article V.

2.11 Maximum Annual Benefit

Maximum Annual Benefit means the total Salary Reduction Contributions a Covered Employee authorizes to his or her Dependent Care Spending Account, according to the election requirements of Section 6.1, for Dependent Care Expense reimbursement, which amount must be not more than $7,500, except as otherwise limited under Section 4.5(B).

2.12 Plan

Plan means the Magna International of America, Inc. Dependent Care Spending Account Plan as herein set forth and as amended from time to time.

2.13 Qualifying Individual

Qualifying Individual means an individual who is either:

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

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

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

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

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

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

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

ARTICLE III

PARTICIPATION

2.14 Participation

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

A. participates in the Cafeteria Plan, and

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

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

2.15 Termination of Participation

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

ARTICLE IV

DEPENDENT CARE REIMBURSEMENT

BENEFIT

2.16 Right to Benefit

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

2.17 Maintenance of Accounts

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

2.18 Amount Payable

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

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

2.19 Dependent Care Expenses

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

A. *Household services*, and

B. *Care* of a Qualifying Individual.

Employment-related, as defined in Code section 21(b), means incurred to enable a Covered Employee to be gainfully employed. In the case of a married Covered Employee, to be

employment-related, the expense must also enable the Covered Employee's Spouse to: be gainfully employed, actively seek gainful employment, or be a *full-time student,* unless the Spouse is described in Section 2.8(B).

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

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

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

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

2.20 Limits

A. On What the Plan Pays

1. For Care Furnished Outside Covered Employee's Household

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

a. described in Section 2.8(A), or

b. described in Section 2.8(B) or (C) who regularly spends at least 8 hours each day in the Covered Employee's home.

Qualified Dependent Care Center means a facility:

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

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

2. To Certain "Highly Compensated" Employees

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

B. On Exclusion from Gross Income

1. Individual Exclusion Limit

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

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

or, if less,

b. the Maximum Annual Benefit.

2. Gross Income Exclusion Limit

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

a. $7,500 (or $3,750 for a married Covered Employee filing a separate federal income tax return),

or, if less,

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

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

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

Earned income is computed without considering community property laws.

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

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

3. Reporting Identifying Information Limit

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

ARTICLE V

EXCLUSIONS

2.21 General Rules

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

1. during the current Plan Year,

2. while the Employee is a Covered Employee, and

3. to allow the Covered Employee (and Spouse, if married) to continue gainful employment (or, if married and the Spouse is unemployed, to allow the Covered Employee's Spouse to actively seek gainful employment or be a full-time student, as defined in Section 4.4, unless the Spouse is described in Section 2.8(B) of the Plan).

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

2.22 Specific Exclusions

The Plan does not reimburse amounts paid in connection with:

A. a Qualifying Individual's overnight camp;

B. services rendered by:

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

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

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

2.23 Conditional Exclusions

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

A. food,

B. clothing,

C. entertainment,

D. education (kindergarten and above), or

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

ARTICLE VI

PROCEDURES

2.24 Enrollment and Election Procedures

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

2.25 Claim Procedures

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services received, is received by the Claim Administrator by March 31 following the Plan Year to which the claim relates. However, if the Covered Employee terminates employment during the Plan Year, any claims incurred prior to the termination date must be submitted to the Claims Administrator within 30 days after the termination date.

2.26 Claim Administrator

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

2.27 Claims Administration

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

2.28 Proof of Claim

As a condition of receiving Plan benefits, claimants must:

A. submit to the Claims Administrator:

1. a properly completed and timely filed claim form,

2. a written declaration stating the dependent care expense has not been reimbursed and is not reimbursable under any other dependent care plan, and

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

B. prove any claimed status.

Alternatively, the Covered Employee may use a debit or credit card provided by the Claims Administrator to pay for dependent care expenses. Covered Employees should keep copies of receipts to substantiate the expense if a request for substantiation is made by the Claims Administrator. The Cafeteria Plan describes additional rules that apply to use of a debit or credit card.

APPENDIX B

MAGNA INTERNATIONAL OF AMERICA, INC.

HEALTH CARE SPENDING ACCOUNT PLAN

ARTICLE I

PLAN ESTABLISHMENT

1.1 Effective Date

The Magna International of America, Inc. Health Care Spending Account Plan (the "Plan") is amended and restated effective January 1, 2026.

1.2 Purpose

The Plan is created exclusively for Employees. The Plan's purpose is to reimburse Covered Employees, as defined in Section 2.1 of this Plan, for Qualifying Medical Expenses, as defined in Section 2.8 of this Plan.

1.3 Qualification

A. ERISA

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

B. Internal Revenue Code

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

1.4 Incorporation By Reference

The term "Cafeteria Plan" as used in this Plan means the Magna International of America, Inc. Cafeteria Plan as defined in Section 1.3 of the Magna International of America, Inc. Welfare Benefit Plan. The terms of the Cafeteria Plan are incorporated by reference wherever they apply to this Plan's operation, to the extent such provisions do not conflict with the provisions of this Plan.

1.5 Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Company, in its sole discretion. may amend or terminate the Plan or any provision of the Plan at any time.

ARTICLE II

DEFINITIONS

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

2.29 Carryover Amount

Carryover Amount means an amount in a Covered Employee's Health Care Spending Account that may be carried over to the next following Plan Year equal to the lesser of (1) the unused amount in the Covered Employee's Health Care Spending Account as of the end of the Plan Year (that is, at the end of the Run-Out Period for that Plan Year) or (2) $500 (or, if higher, 20% of the Maximum Annual Benefit.)

2.30 Covered Employee

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

2.31 Dependent

Dependent means a Covered Employee's:

A. Spouse, and

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

2.32 Effective Date

Effective Date means the date the amended and restated Plan becomes operative; the Effective Date is January 1, 2026. The original effective date of the Plan was January 1, 2006.

2.33 Exclusions

Exclusions means the exclusions in Article V.

2.34 Health Care Spending Account

Health Care Spending Account means the notational account established on behalf of each Covered Employee who elects the Health Care Spending Account premium payment benefit under the Cafeteria Plan to which the Covered Employee allocates Salary Reduction Contributions for the reimbursement of Qualifying Medical Expenses. A Covered Employee may elect a “General Purpose” Health Care Spending Account, which will reimburse any Qualifying Medical Expense. To retain eligibility to make contributions to a Health Savings Account, a Covered Employee who is enrolled in a Company-sponsored high deductible health plan must enroll in a “Limited Purpose” Health Care Spending Account, which will reimburse only eligible dental and vision expenses.

2.35 Maximum Annual Benefit

Maximum Annual Benefit means the total Salary Reduction Contributions a Covered Employee authorizes to his or her Health Care Spending Account, according to the election procedures of Section 6.1, for Qualifying Medical Expense reimbursement, which amount must be not more than $2,500, or if more, the maximum amount allowed under Section 125(i) of the Code.

2.36 Plan

Plan means the Magna International of America, Inc. Health Care Spending Account Plan as herein set forth and as amended from time to time.

2.37 Qualifying Medical Expenses

Qualifying Medical Expenses under a General Purpose Health Care Spending Account means a Covered Employee's and a Dependent's expenses *incurred* during the Plan Year for medical care, as defined in Code section 213(d)(1)(A) and (B). To be a Qualifying Medical Expense, the medical care must be essential to diagnose, cure, mitigate, treat, or prevent a disease or disorder or to affect an unsound structure or function of the mind or body. A Qualifying Medical Expense under a Limited Purpose Health Care Spending Account means only eligible dental and vision care expenses. *Incurred* refers to the date the medical care is provided — not to the date charged, billed, or paid

2.10 Run-Out Period

Run-Out Period is the period immediately following the end of a Plan Year during which a Covered Employee can submit a claim for reimbursement of Qualifying Medical Expenses incurred in that Plan Year. The Run-Out Period is set forth in Section 6.2.

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ARTICLE III

PARTICIPATION

2.38 Participation

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

A. participates in the Cafeteria Plan, and

B. has allocated an amount to his or her Health Care Spending Account or has a Carryover Amount from a prior Plan Year.

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

2.39 Termination of Participation

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

ARTICLE IV

MEDICAL EXPENSE BENEFIT

2.40 Right to Benefit

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

2.41 Maintenance of Accounts

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

2.42 Amount Payable

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

2.43 Qualifying Medical Expenses

Qualifying Medical Expenses, as defined in Section 2.9, under a General Purpose Health Care Spending Account that are not covered by any other health plan include, for example, expenses for:

A. abortion, if legal where performed

B. acupuncture

C. ambulance service

D. birth control pills

E. breast pumps and supplies that assist lactation

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

G. Christian Science practitioners

H. crutches

I. dental treatment

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

K. eye examinations, eyeglasses, and contact lenses

L. hearing examinations and hearing aids

M. hospital services

N. laboratory fees and diagnostic testing

O. mental health treatment

P. nursing home services, including meals and lodging

Q. nursing services

R. organ transplant expenses

S. non-prescription drugs or over-the-counter supplies including menstrual care products

T. oxygen and oxygen equipment

U. prescription drugs

V. prostheses

W. smoking cessation products

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

Y. sterilization

Z. substance abuse treatment

AA. surgery

BB. therapy

CC. transportation for medical reasons

DD. wheelchairs

EE. X-ray fees

Qualifying Medical Expenses under a Limited Purpose Health Care Spending Account includes only eligible dental and vision expenses.

2.44 Limits

The Plan reimburses Qualifying Medical Expenses only to the extent the charge is not compensated for by any prepaid health coverage, group health plan, medical insurance, or otherwise. Qualifying Medical Expenses include deductibles and co-payments if not reimbursed through coordination of benefits with a secondary payor.

4.6 Carryover From Prior Plan Year

A Covered Employee's unused balance at the end of a prior Plan Year may be used (a) for expenses incurred in the prior Plan Year, but only if claimed during the Run-Out Period that begins at the end of the prior Plan Year, or (b) to the extent of the permitted Carryover Amount, for Qualifying Medical Expenses that are incurred at any time in the current Plan Year. If the Covered Employee is enrolled in a non-high deductible health plan in a Plan Year and enrolls in a Company-sponsored high deductible health plan in the immediately following Plan Year, any Carryover Amount will be automatically carried over to a Limited Purpose Health Care Spending Account.

4.7 Forfeiture of Account

If a Covered Employee incurs aggregate Qualifying Medical Expenses in an amount which is less than the dollar amount of coverage he or she has elected for a Plan Year, plus any available Carryover Amount, any remaining amount greater than the Carryover Amount in his or her Health Care Spending Account shall be forfeited as of the end of the Run-Out Period applicable to that Plan Year.

ARTICLE V

EXCLUSIONS

2.45 General Rules

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

1. during the current Plan Year, and

2. while the Employee is a Covered Employee.

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

2.46 Specific Exclusions

The Plan does not reimburse amounts paid in connection with:

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

B. custodial or domiciliary care,

C. diaper service,

D. funeral and burial expenses,

E. health club membership fees and dues,

F. household and domestic help,

G. illegal services and supplies,

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

I. meals and lodging at a nonmedical facility,

J. maternity clothes or uniforms,

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

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

M. schooling or tuition for scholastic improvement or discipline,

N. social activities like dancing or swimming lessons,

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

P. transportation for nonmedical reasons,

Q. trips or vacations, and

R. long term care expenses.

ARTICLE VI

PROCEDURES

2.47 Enrollment and Election Procedures

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

2.48 Claim Procedures

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services received, is received by the Claim Administrator by March 31 following the Plan Year to which the claim relates (the "Run-Out Period"). However, if the Covered Employee terminates employment during the Plan Year, any claims incurred prior to the termination date must be submitted to the Claims Administrator within 30 days after the termination date.

2.49 Claim Administrator

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

2.50 Claims Administration

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

2.51 Proof of Claim

As a condition of receiving Plan benefits, claimants must:

A. submit to the Claims Administrator:

1. a properly completed and timely filed claim form,

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

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

B. prove any claimed status.

Alternatively, the Covered Employee may use a debit or credit card provided by the Claims Administrator to pay for Qualifying Medical Expenses. Covered Employees should keep copies of receipts to substantiate the expense if a request for substantiation is made by the Claims Administrator. The Cafeteria Plan describes additional rules that apply to use of a debit or credit card.

APPENDIX C

APPLICABLE INCORPORATED DOCUMENTS

APPLICABLE DOCUMENT	APPLICABLE BENEFIT
Administrative Services Only Agreement between the Company and Blue Cross Blue Shield of Michigan and Benefit Booklet	Medical Benefits
_____ Agreement between the Company and Express Scripts	Prescription Drug Benefits
_____ and certificate of coverage issued by Delta Dental	Dental Benefits
Group Policy and certificate of coverage issued by Vision Service Plan	Vision Benefits
Contract between the Company and Workplace Options (WPO)	Employee Family Assistance Plan
Group Policy and certificate of coverage issued by Hartford	Group Term Basic Life/Basic Dependent Life Benefits
Group Policy and certificate of coverage issued by Hartford	Accidental Death & Dismemberment Benefits
Group Policy and certificate of coverage issued by Hartford	Basic Long Term Disability
_____ between the Company and Hartford	Short Term Disability
Group Policy and certificate of coverage issued by Hartford	Buy Up Long Term Disability Benefits
Group Policy and certificate of coverage issued by Hartford	Supplemental Life/Supplemental Dependent Life Benefits
Group Policy and certificate of coverage issued by Hartford	Supplemental AD&D Benefits

Group Policy and certificate of coverage issued by Hartford	Business Travel Accident Benefits
Summary Plan Description	Retiree Premium Reimbursement Plan

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

APPENDIX D

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

Benefit Administrators

Human Resources Personnel

Other Employees designated in Magna International of America's Group Health Plans' HIPAA Policies and Procedures

APPENDIX E

PARTICIPATING EMPLOYERS

Magna International of America, Inc. and its participating affiliates

Magna Mirrors of America, Inc. and its participating affiliates

The Plan Administrator shall maintain a current list of the Participating Employers. The list of Participating Employers shall be subject to modification without formal amendment of the Plan.

APPENDIX F

SPECIAL RULES RELATING TO COVID-19

This Appendix F is a supplement to the Plan that applies during the duration of the COVID-19 public health emergency period declared by the Department of Health and Human Services ("HHS") on January 31, 2020. Unless indicated otherwise, these rules will expire with the termination of the COVID-19 public health emergency period on May 11, 2023.

1.1 Health Care Flexible Spending Account Rules

A. Participants in the Health Care Flexible Spending Account are permitted to carry over unused balances from 2020 to 2021, and to carry over unused balances from 2021 to 2022.

B. If a Covered Employee terminated employment in 2020 or 2021, the Covered Employee may be reimbursed for claims incurred following the termination date and before the last day of the Plan Year from any remaining payroll contributions credited to the Covered Employee's account.

1.2 Dependent Care Flexible Spending Account Rules

A. Participants in the Dependent Care Flexible Spending Account are permitted to carry over unused balances from 2020 to 2021, and to carry over unused balances from 2021 to 2022.

B. Additionally, the claims period for a dependent who "ages out" by turning 13 years old during the COVID-19 public health emergency is extended. The limiting age is 14 for 2021 but this only applies to Dependent Care Flexible Spending Account funds that remained unspent at the end of 2020.

1.3 Mid-Year Election Changes

A Covered Employee is allowed to change his or her Health Care Flexible Spending Account or Dependent Care Flexible Spending Account election at any time in 2021, even if the Covered Employee did not otherwise experience a change in status event.

1.4 Coverage for COVID-19 Testing

A. Coverage for in vitro diagnostic testing to detect SARS-CoV-2 (including testing to detect antibodies against SARS-CoV-2) or diagnose COVID-19, and the administration of these tests at no cost:

1. That are approved by the FDA;

2. For which the developer has asked for or intends to request FDA emergency-use approval, until FDA approval of the test is denied or the developer does not timely request authorization;
3. That are developed in states that have informed the Department of Health and Human Services (HHS) of their intention to review COVID-19 tests; and
4. That are determined by HHS to be appropriate.

B. Coverage is also provided for items and services furnished during an office visit (whether in-person or using telehealth, and including facility fees), urgent care center visit, or emergency room visit that results in an order for or administration of COVID-19 testing. These items and services are covered only to the extent they relate to screening the Covered Employee or a covered spouse or dependent to determine if testing is needed, or for providing or administering a COVID-19 test.

C. Coverage also is provided for:

1. At-home and point-of-care testing.
2. Testing at state-administered or locality-administered sites.

For individuals who receive multiple COVID-19 tests, coverage will be provided for each test and related items and services, as medically appropriate.

1.5 **Coverage for COVID-19 Preventive Services**

The provisions in this Section 1.5 are not limited to the duration of the COVID-19 public health emergency.

The Plan will cover at no cost all immunizations/vaccines for COVID-19 with a recommendation that makes them qualifying coronavirus preventive services under the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), without cost-sharing, even if the vaccines are not listed for routine use on immunization schedules issued by the CDC. This includes the related administration of the vaccines, and any other "qualifying coronavirus preventative service" under the CARES Act as an item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is either:

1. An evidence-based item or service that has in effect a rating of "A" or "B" in the current U.S. Preventive Services Task Force recommendations; or
2. An immunization that has in effect a CDC/Advisory Committee on Immunization Practices recommendation regarding the individual involved, whether or not the immunization is recommended for routine use.

1.6 **Certain Plan Deadlines Extended During Outbreak Period**

Under Department of Labor regulations, the period from March 1, 2020, until 60 days after the announced end of the COVID-19 national emergency (or such other date announced by the Department in future guidance) is disregarded for all Plan participants, beneficiaries, qualified beneficiaries, or claimants wherever located in calculating certain benefit-related timeframes. This

is referred to as the "outbreak period." The Federal government announced that the COVID-19 national emergency ended on May 11, 2023, which means that the outbreak period ended on July 10, 2023. Thus, the special rules described in this Appendix will no longer apply to Plan deadlines for events occurring after July 10, 2023, and the deadlines in the Plan will control.

The outbreak period is limited to:

1. One year from the date the Plan participants, beneficiaries, qualified beneficiaries, or claimants were first eligible for relief; or
2. 60 days after the announced end of the COVID-19 national emergency (July 10, 2023).

A. COBRA Continuation Coverage

The Plan will disregard the outbreak period for determining the following deadlines for participants or qualified beneficiaries:

1. The 60-day period for electing COBRA.
2. The due date(s) for making COBRA premium payments.
3. The date for individuals to notify the Plan of a COBRA qualifying event or disability determination.

B. HIPAA Special Enrollment Period

HIPAA special enrollment rights allow a Covered Employee to enroll the Covered Employee and/or his/her dependents in Medical and Prescription Drug coverage following certain circumstances.

1. If the Covered Employee (or his/her dependents) loses other medical or prescription drug coverage or when a person becomes the Covered Employee's dependent by birth, adoption, placement for adoption or marriage, the Covered Employee generally has 31 days to enroll in Medical and Prescription Drug benefits.

2. If the Covered Employee loses eligibility for coverage under a state Medicaid or CHIP program, or if the Covered Employee becomes eligible for state premium assistance under Medicaid or CHIP, the Covered Employee generally has 60 days to enroll in Medical and Prescription Drug benefits.

The Plan will disregard the outbreak period for purposes of calculating the 31 or 60-day HIPAA special enrollment period.

C. Benefit Claim and Appeals Deadlines

The Plan describes the benefit claim and appeal deadlines that apply to those Plan benefits that are covered by ERISA. The following deadlines are impacted:

1. The Plan will disregard the outbreak period for determining the deadline by which benefit claims have to be submitted and appealed.
2. The Plan will also disregard the outbreak period for determining the deadline by which a Participant must file or perfect a request for external review of a medical benefits claim.

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