TENET EMPLOYEE BENEFIT PLAN

As Amended and Restated
Effective January 1, 2017
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As Amended and Restated Effective January 1, 2017

W I T N E S S E T H:

WHEREAS, effective October 1, 1977, National Medical Enterprises, Inc. established the National Medical Enterprises, Inc. Employee Medical Benefit Plan (the “Plan”) for the benefit of its employees;

WHEREAS, the Plan was amended and restated as of January 1, 1993, as the National Medical Enterprises, Inc. Employee Benefit Plan, to reflect the adoption of the Plan by those subsidiaries and affiliates of National Medical Enterprises, Inc. (“NME”) who formerly were sponsors of the P.I.A. Employee Medical Benefit Plan (“PIA Plan”);

WHEREAS, in connection with such plan merger, the trust agreements used to fund the Plan and the PIA Plan were merged into a single trust denominated the National Medical Enterprises, Inc. Employee Benefit Trust (the “Employee Benefit Trust”);

WHEREAS, the name of the Plan was changed effective as of March 1, 1995, to the Tenet Employee Benefit Plan and the name of the Employee Benefit Trust was changed effective as of March 1, 1995 to the Tenet Employee Benefit Plan Trust (the “VEBA”) to reflect the merger of NME and American Medical Holdings, Inc., parent of American Medical International, Inc. (“AMI”), and the subsequent change in the name of the merged company to Tenet Healthcare Corporation (the “Company”);

WHEREAS, effective as of January 1, 1996, the AMI health and welfare plans were merged with and into the Plan, with this Plan being the surviving plan;

WHEREAS, effective as of January 1, 1998, pursuant to Tenet’s purchase of OrNda Healthcorp (“OrNda”), the OrNda health and welfare plans were merged with and into the Plan;

WHEREAS, the Plan was amended and restated effective January 1, 1996 to reflect the above- plan mergers;

WHEREAS, the Plan was amended effective April 14, 2003 to comply with the privacy and related rules promulgated under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”);

WHEREAS, the Company amended and restated the Plan effective January 1, 2003, to (i) incorporate the HIPAA privacy amendment, (ii) comply with recent changes in the law including, but not limited to, the new claims rules issued by the Department of Labor, and (iii) clarify the manner in which benefits under the Plan are treated for purposes of the Annual Report, Form 5500;

WHEREAS, effective January 1, 2003, all of the benefits provided under this Plan except the insured executive medical benefits (“ExecuPlan”) specified under Appendix A in effect at that time were filed under a single Annual Report, Form 5500, under plan number 515 (“Plan 515”) [prior to January 1, 2003, this single plan was filed under two Form 5500 filings using plan numbers 515 and 504] and during its existence the ExecuPlan was filed as a separate plan under plan number 517 (“Plan 517”);
WHEREAS, all employee contributions to fund the benefits provided pursuant to Plan 515 as described herein were held in the VEBA and certain benefits provided pursuant to Plan 515 were paid from the VEBA; however, neither the contributions to nor the benefits provided under the ExecuPlan were provided through the VEBA;

WHEREAS, the Company amended and restated the Plan effective January 1, 2005, unless a later date was set forth in such amendment and restatement, to (i) comply with the security provisions of HIPAA; (ii) comply with changes to the regulations issued by the Internal Revenue Service concerning the continuation of coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended; (iii) address changes to the definition of “dependent” in Internal Revenue Code section 152 made by the Working Families Tax Relief Act of 2004; and (iv) allow for coverage under the Plan of an Employee’s domestic partner who meets the “Criteria for Domestic Partnership Status” attached as Appendix B to this Plan;

WHEREAS, the Company amended the Plan, effective January 1, 2007, to allow for pre-tax payment of “health savings account” contributions through the Cafeteria Program;

WHEREAS, the Company amended the Plan, effective July 1, 2007, to (i) reflect the termination of the VEBA, (ii) clarify the payment of after-tax contributions, (iii) clarify the definition of “qualified beneficiaries” for COBRA coverage, and (iv) vest appointment authority over the Benefits Administration Committee in the Senior Vice President of Human Resources;

WHEREAS, the Company amended and restated the Plan, effective January 1, 2011 (or such other effective date as is set forth herein) to (i) comply with the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 effective as of January 1, 2011; (ii) reflect the termination of ExecuPlan; and (iii) make certain other clarifying changes;

WHEREAS, the Company amended and restated the Plan, generally effective September 16, 2013, to reflect changes in the law regarding recognition of same-sex spouses and effective March 1, 2014 to delegate to the Daily Administrator the authority to amend the Plan;

WHEREAS, the Daily Administrator amended and restated the Plan, generally effective January 1, 2015 unless an earlier or later date is stated, to update the Major Life Events to comply with guidance issued under the Affordable Care Act, add the Health Reimbursement Account Program, make certain other administrative clarifications and update Appendix A; and

WHEREAS, the Daily Administrator desires to amend and restate the Plan, generally effective January 1, 2017 unless an earlier date is stated, to add language regarding subrogation, assignment and payment of benefits, reflect that certain affiliates do not participate in the Plan, clarify when prior service for employees of acquired facilities or acquired employee groups and outsourced operations will be considered under the Plan, and make certain other administrative clarifications.
NOW, THEREFORE, the Plan is hereby amended and restated as follows:

EXECUTED this 27 day of March, 2017.

TENET HEALTHCARE CORPORATION

By:

Printed Name: Paul Slavin
Title: VP, Total Rewards & Workforce Analytics
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ARTICLE I — DEFINITIONS AND CONSTRUCTION

1.1 Definitions

The following terms have the respective meanings set forth below, unless the context clearly indicates otherwise:

(a) **AD&D Benefit Program**: The Component Program providing accidental death and dismemberment benefits to Covered Persons.

(b) **Administrative Agreement**: The agreement entered into with each individual or entity providing administrative services with respect to one or more Component Programs.

(c) **Administrative Provider**: Any individual or entity operating under an Administrative Agreement to provide administrative services with respect to any benefits offered under one or more of the Component Programs.

(d) **Affiliate**: Any entity that is a member of the same group of affiliated entities as the Company within the meaning of sections 414(b), (c) or (m) of the Code except that for purposes of this definition 51 percent will be substituted for 80 percent.

(e) **Approved HSA Vendor**: An HSA vendor that has been approved by the Company to market HSA products to its employees and to receive employer HSA contributions, if any, and employee pre-tax HSA contributions made through the Cafeteria Program. Notwithstanding the foregoing, an HSA Eligible Participant may transfer, at any time, his or her HSA account balance to an HSA vendor that is not an Approved HSA Vendor (but any future employee health savings account contributions made by or on behalf of such HSA Eligible Participant to a health savings account maintained by a vendor that is not an Approved HSA Vendor must be made on after-tax basis and not pre-tax through the Cafeteria Program).

(f) **Business Associate**: An individual who or entity that, other than an Employee of the Company or a Participating Employer, provides services to the Health Care Components of the Plan, such as an Administrative Provider, COBRA vendor or utilization review organization.

(g) **Business Travel Accident Benefit Program**: The Component Program providing business travel accident benefits to Covered Persons.

(h) **Cafeteria Component Program**: Each Component Program in which Participants pay for benefits on a pre-tax basis or an after-tax basis pursuant to section 125 of the Code. Specifically, the Cafeteria Component Programs are: (i) the Medical Benefit Program, (ii) the Dental Benefit Program, (iii) the Vision Benefit Program, (iv) the Health Care Spending Account Program, (v) the Dependent Day Care Spending Account Program, (vi) the Health Reimbursement Account Program, and (vii) any Health Savings Accounts established by HSA Eligible Participants. As required by COBRA, FMLA, USERRA or other applicable law, Participants may pay for benefits under the Cafeteria Component Programs on an after-tax basis as provided in this Plan. In
addition, Participants will pay for benefits under the Disability Benefit Program on an after-tax basis under this Plan, which may be through the Cafeteria Component Program. Participants will pay for benefits under the AD&D Benefit Program, Life Benefit Program and Long Term Care Benefit Program on an after-tax basis under this Plan, which will be made outside of the Cafeteria Component Program.

(i) **Child or Children:** The child (or children) of an Employee who is (or are) eligible to participate in a Component Program.

(j) **COBRA:** The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and any regulations or rulings issued thereunder.

(k) **COBRA Beneficiary:** Each (i) qualified beneficiary within the meaning of Section 5.3 who has elected continuation of coverage pursuant to Article V and thereby is covered under the Plan, (ii) qualified beneficiary who has elected continuation of coverage pursuant to the COBRA provisions set forth in a Component Program Document and thereby is covered under the Plan, and (iii) other individual covered under the Plan pursuant to Section 5.9(a).

(l) **Code:** The Internal Revenue Code of 1986, as amended, and any regulations or rulings issued thereunder.

(m) **Committee:** The Tenet Benefits Administration Committee, which is the “Plan Administrator” of the Plan as provided in Section 13.1.

(n) **Company:** Tenet Healthcare Corporation. For purposes of Articles XV and XVI regarding the HIPAA privacy and security requirements, the term “Company” also includes any Affiliate that has adopted the Plan as a Participating Employer.

(o) **Compensation:** Unless otherwise specifically provided in a Component Program, the total of all wages, salaries, fees, and other amounts that are paid by the Employer to or for the benefit of a Participant for services performed for the Employer, which are required to be reported on the Participant’s federal income tax withholding statement (Form W-2).

(p) **Component Program:** A benefit program selected by the Company and listed in Appendix A to the Plan. The types and/or terms of the Component Programs may be revised from time to time without the need for a formal amendment to the Plan in which case a revised Appendix A will be attached hereto.

(q) **Component Program Document:** The written documents (i.e., insurance policies, HMO contracts, summary plan descriptions, pamphlets and brochures) setting forth the terms of the applicable Component Program, the provisions of which are incorporated herein by this reference.

(r) **Condition:** Any sickness, injury, or other mental or physical malady that may give rise to the payment of benefits under the Plan.

(s) **Contact Person:** The person appointed to serve as the HIPAA privacy contact person pursuant to the Privacy Manual for purposes of inquiries and complaints.
Covered Dependent: Each Dependent who is covered under the Plan pursuant to Section 3.5.

Covered Person: Each Participant, Covered Dependent, and COBRA Beneficiary. For purposes of Article XV and XVI regarding HIPAA, “Covered Person” means an employee, spouse, or dependent that is enrolled in one or more of the Health Care Components.

Daily Administrator: The Health and Welfare Department of the Company which is responsible for the day-to-day administration of the Plan. The Director of Benefits for the Company is authorized to enter into and execute documents on behalf of the Daily Administrator.

Dental Benefit Program: The Component Program providing group dental benefits to Covered Persons.

Dependent: Each (i) Spouse of a Participant, (ii) Child of a Participant, (iii) Domestic Partner of a Participant, and (iv) other dependent of a Participant within the meaning of section 152 of the Code who is eligible for coverage under a Component Program; provided, however, that the definition of “Dependent” will be modified as necessary to conform with the underlying section applicable to each Component Program, as applicable. For instance, for purposes of the Health Care Components, whether a person is a dependent under section 152 of the Code will be determined without regard to sections 152(b)(1) and (b)(2) of the Code, which contain certain exceptions to the definition of dependent, and without regard to section 152(d)(1)(B) of the Code, which contains a gross income limitation for a qualifying relative. Additionally, effective January 1, 2011, a Dependent under the Medical Benefit Program and the Health Care Spending Account Program will include a “child” as described in section 152(f)(1) of the Code under the age of 26.

Dependent Day Care Spending Account: The Tenet Healthcare Corporation Dependent Day Care Spending Account, which is a Component Program providing Spending Accounts for reimbursement of dependent-care expenses, pursuant to sections 125 and 129 of the Code, but will not be a separate fund or otherwise a segregation of assets, merely a record-keeping account.

Disability Benefit Program: The Component Program providing short-term and long-term disability benefits to Covered Persons.

Domestic Partner: A person of the same or opposite sex as the Participant who has entered into a domestic partnership with the Participant that satisfies the “Criteria for Domestic Partnership Status” attached hereto as Appendix B. Appendix B may be revised from time to time without the need for formal amendment to the Plan, in which case a revised Appendix B will be attached hereto

Effective Date: January 1, 2017, except as otherwise stated herein or required by law.

Electronic Media: For purposes of the HIPAA Security Standards:
(i) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(ii) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, if the information being exchanged did not exist in electronic form before the transmission.

(dd) **Electronic Protected Health Information or ePHI**: PHI that is created, received, maintained or transmitted in Electronic Media by or on behalf of the Plan.

(ee) **Employee**: Each individual employed or formerly employed by the Employer or each individual who is a current or former member of the Company’s Board of Directors who is eligible for coverage under a Component Program; provided, however, that “Employee” will not include any employee:

(i) who is a leased employee within the meaning of section 414(n) of the Code or is determined by the Employer to be an independent contractor (even if such leased employee or independent contractor is subsequently determined by the Internal Revenue Service, the Department of Labor, a court of competent jurisdiction or the Employer to be a common law employee of the Employer); or

(ii) whose terms and conditions of employment are governed by a collective bargaining agreement unless the agreement provides for his coverage under the Plan.

Service or employment completed by an Employee of an acquired facility or an acquired employee group before such facility or group became an Affiliate or part of an Affiliate will be taken into account for purposes of the Plan to the extent provided in the acquisition agreement or similar document, including payroll records. Likewise, service or employment completed by an Employee who was part of an outsourced function, department or group, that is reassumed by the Employer or an Affiliate will be taken into account for purposes of the Plan.

(ff) **Employee Assistance Program**: The Component Program providing employee assistance benefits to Covered Persons.

(gg) **Employer**: The Company and each Participating Employer.

(hh) **ERISA**: The Employee Retirement Income Security Act of 1974, as amended and any regulations or rulings issued thereunder.
(ii) **FMLA**: The Family and Medical Leave Act of 1993, as amended, and any regulations or rulings issued thereunder.

(jj) **FMLA Coverage**: Coverage under a Health Care Component during an FMLA Leave.

(kk) **FMLA Leave**: A leave of absence taken pursuant to the FMLA.

(ll) **GINA**: the Genetic Information Nondiscrimination Act of 2008 as it may be amended from time to time, and any regulations or rulings issued thereunder.

(mm) **Health Care Components**: The designated health care components of the Plan, which consist of the following group health plans within the meaning of section 5000(b)(1) of the Code or section 607(1) of ERISA: (i) the Medical Benefit Program component (includes all insured and self-funded medical benefits provided), (ii) the Dental Benefit Program component, (iii) the Vision Benefit Program component, (iv) the Health Reimbursement Account Program, and (v) the Health Care Spending Account component. In addition, the term “Health Care Components” includes any other component that is offered under the Plan that provides “health care” within the meaning of HIPAA, including (i) the Long-Term Care Benefit Program component, (ii) the Employee Assistance Program component, and (iii) any Voluntary Benefit Program component providing health care.

(nn) **Health Care Reform**: The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, and any regulations or rulings issued thereunder.

(oo) **Health Reimbursement Account Program**: The Tenet Healthcare Corporation Health Reimbursement Account Program, which is a Component Program providing Health Reimbursement Accounts for reimbursement of medical expenses, pursuant to sections 105 and 106 of the Code, but will not be a separate fund or otherwise a segregation of assets, but merely a record-keeping account.

(pp) **Health Savings Account or HSA**: A “health savings account” within the meaning of section 223(d) of the Code that is established or maintained by an HSA Eligible Participant and provided by an Approved HSA Vendor.

(qq) **Health Care Spending Account**: The Tenet Healthcare Corporation Health Care Spending Account, which is a Component Program providing Spending Accounts for reimbursement of medical expenses, pursuant to sections 125 and 105(b) of the Code, but will not be a separate fund or otherwise a segregation of assets, but merely a record-keeping account.

(rr) **HIPAA**: The Health Insurance Portability and Accountability Act of 1996, as may be amended from time to time. The privacy requirements of HIPAA with respect to the Plan are set forth in Article XV. The security requirements of HIPAA are set forth in Article XVI.
HIPAA Regulations: The regulations promulgated pursuant to HIPAA with respect to the privacy and security of PHI as set forth in 45 C.F.R. Parts 160 and 164 as in effect or as amended from time to time. A reference to a section of the HIPAA Regulations will include such section as it may be subsequently amended or renumbered from time to time. Further, certain capitalized terms used in this Article or in Article XV and Article XVI that are not defined herein will have the meaning ascribed to such terms under the HIPAA Regulations.

HMO: Any health maintenance organization or similar organization or network of individuals or organizations that has contracted to provide medical, mental, and/or other health-related benefits to Participants and Covered Dependents.

HSA Eligible Participant: A Participant in a Medical Benefit Program option that is a “high deductible health plan” within the meaning of Code section 223(c)(2) and who is an “eligible individual” within the meaning of Code section 223(c)(1).

Information System: For purposes of the HIPAA Security Standards, an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

Insurer: Any insurance company that has contracted to provide benefits under a Component Program.

Life Benefit Program: The Component Program providing life insurance benefits to Covered Persons.

Long-Term Care Benefit Program: The Component Program providing long-term care insurance benefits to Covered Persons.

Major Life Event: May include any of the following events as specified in the Component Program Document:

(i) Events that change an Employee's legal marital status, including marriage, death of Spouse, divorce, legal separation, or legal annulment;

(ii) Events that change an Employee's number of Children, including birth, adoption, placement for adoption, or death of a Child;

(iii) A termination or commencement of employment or a change in employment status of the Employee, Spouse or Child;

(iv) A reduction or increase in hours of employment by the Employee, Spouse, or Child, including a switch between part-time and full-time status, a strike or lockout, or a commencement or return from an unpaid leave of absence;

(v) An event that causes a Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as may be provided in the applicable Component Program;
(vi) A change in the place of residence or work of the Employee, Spouse, or Child that results in a gain or loss of coverage under a Component Program;

(vii) The loss of health coverage or addition of a Dependent which gives rise to the special enrollment rights provided in section 9801(f) of the Code;

(viii) An election change made by the Spouse, former Spouse or Child under another employer-sponsored plan, including an annual enrollment election or a permissible change in status election under such plan that results in a gain or loss of coverage under such plan;

(ix) With respect to an election to revoke coverage in the Medical Benefit Program only, a reasonably expected reduction in hours of the Employee below 30 hours per week on average, regardless of whether such reduction would result in a loss of coverage under the Medical Benefit Program, provided, that the Employee expresses his intent to enroll himself and his Dependents who lose coverage under the Medical Benefit Program, in health coverage under the health insurance market place exchange with such coverage becoming effective no later than the first day of the second month following the month that includes the date that coverage in the Medical Benefit Program is revoked; or

(x) With respect to an election to revoke coverage in the Medical Benefit Program, an annual or special enrollment period under the health insurance market place exchange where the Employee reasonably expresses his intent to enroll himself and his Dependents who lose coverage under the Medical Benefit Program in health coverage under the health insurance market place exchange with such coverage becoming effective no later than the day immediately following the day that coverage in the Medical Benefit Program is revoked.

(aaa) **Medical Benefit Program**: The Component Program providing group medical benefits to Covered Persons.

(bbb) **Medicare**: The medical care benefits program provided under title XVIII of the Social Security Act of 1965, as amended.

(ccc) **Mental Health Act**: The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as it may be amended from time to time, and any regulations or rulings issued thereunder.

(ddd) **Michelle’s Law**: Public Law 110-381 as it may be amended from time to time, and any regulations or rulings issued thereunder.

(eee) **Non-Health Care Components**: The non-health care components of the Plan which consist of (i) the Disability Benefit Program component, (ii) the Dependent Day Care Spending Account component, (iii) the AD&D Benefit Program component, (iv) the Life Benefit Program component, and (v) the Business Travel Accident Benefit Program component.
(fff) **Participant:** Each Employee who is a participant in the Plan pursuant to Article III.

(ggg) **Participating Employer:** Any Affiliate of the Company that has adopted all or a portion of the Plan. Unless specified otherwise by a resolution of the Committee or other written instrument, such as an acquisition or similar agreement, each 80% or more owned Affiliate will automatically become a Participating Employer in this Plan and the Component Programs. Each less than 80% owned Affiliate but 51% or more owned Affiliate will become a Participating Employer in this Plan to the extent the Company determines to offer the Plan to such Affiliate’s employees. For this purpose any such Affiliate’s commencement of pre-tax contributions or after-tax contributions on behalf of its Employee-Participants will evidence its formal adoption of the Plan. A Participating Employer may terminate its participation in this Plan and/or any of the Component Programs by written notice to the Company. Likewise, the Company may terminate a Participating Employer’s participation in this Plan and/or any of the Component Programs at any time by written notice to such Employer.

A list of the 80% or more owned Affiliates who do not participate in the Plan is set forth in Appendix C. Appendix C may be revised from time to time without the need for a formal amendment to the Plan in which case a revised Appendix C will be attached hereto.

(hhh) **Plan:** The Tenet Employee Benefit Plan which sets forth the single administrative document that governs administration of the benefits provided through the Component Programs.

(iii) **Plan Administrator:** The plan administrator appointed pursuant to section 13.1 of the Plan. As of the Effective Date, the Committee is the Plan Administrator.

(jjj) **Plan Year:** The calendar year.

(kkk) **PPO:** Any preferred provider organization or other similar organization or arrangement with which the Employer has contracted to provide medical, mental, and/or other health-related benefits—including dental, vision, or pharmacy benefits—for Participants and Covered Dependents.

(lll) **Privacy Manual:** The Company’s Protected Health Information Policies and Procedures Manual.

(mmm) **Privacy Officer:** The individual or entity appointed to serve as the Plan's Privacy Officer pursuant to the Privacy Manual.

(nn) **Privacy Rules:** The rules pertaining to privacy of Protected Health Information set forth in subpart E of part 164 of the HIPAA Regulations.

(ooo) **Protected Health Information or PHI:** Individually identifiable health information which is protected pursuant to HIPAA and the HIPAA Regulations.

(ppp) **Spending Accounts:** The Dependent Day Care Spending Account and the Health Care Spending Account.
(qqq) **Security Incident**: The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an Information System.


(sss) **Security or Security Measures**: All Administrative, Physical and Technical Safeguards in an Information System.

(ttt) **Security Officer**: The individual or entity appointed to serve as the Plan’s Security Officer pursuant to Section 16.9 of the Plan.

(uuu) **Security Standards**: The security standards set forth in sections 164.306 (regarding general security standards), 164.308 (regarding Administrative Safeguards), 164.310 (regarding Physical Safeguards), 164.312 (regarding Technical Safeguards), 164.314 (regarding organizational requirements), and 164.316 (regarding policies and procedures and documentation requirements) of the HIPAA Regulations, individually or collectively, as the context requires.

(vvv) **SHI**: Summary health information (i.e. information that summarizes the claims history, claims expense or type of claims experienced by Covered Persons under the Plan) as such term is described in section 164.504 of the HIPAA Regulations.

(www) **Spouse**: The legal spouse of an Employee, including a common law spouse or a same-sex spouse.

(xxx) **Third Party**: Any individual who or entity that may be liable to a Covered Person for a Condition or for payment of damages or expenses related to a Condition. This term includes first-party automobile insurance coverage such as personal-injury-protection/medical coverage and uninsured/underinsured motorist coverage of the Covered Person.

(yyy) **USERRA**: The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and any regulations or rulings issued thereunder.

(zzz) **USERRA Coverage**: Coverage under a Health Care Component pursuant to USERRA

(aaaa) **USERRA Leave**: A leave of absence taken pursuant to USERRA

(bbbb) **Vision Benefit Program**: The Component Program providing group vision benefits to Covered Persons.

(cccc) **Voluntary Benefit Programs**: The Component Programs providing voluntary benefit offerings that may be elected by eligible Employees. As of the Effective Date, the Voluntary Benefit Programs include accident-only insurance, critical illness insurance and Hyatt legal services.

(dddd) **Workforce**: Employees and agents of the Company who perform work for the Plan under the direct control of the Plan.
1.2 **Number and Gender**

Where appropriate, the singular includes the plural, and vice versa; and the masculine gender includes the feminine gender, and vice versa.

1.3 **Miscellaneous Construction**

The headings of Articles and Sections are solely for convenience. All references to the capitalized terms “Sections,” “Articles,” “Paragraphs,” “Clauses” and the like are to this document unless otherwise indicated. The terms “herein” and “hereof,” as well as other similar compounds of “here,” refer to the entire document and not to any particular part, unless the context clearly indicates otherwise. The terms “includes” and “including” mean “includes but is not limited to” and “including but not limited to,” respectively.

1.4 **Reference to Plan Includes Component Programs**

Any reference to the Plan includes each Component Program unless otherwise indicated.

1.5 **Incorporation of Component Programs**

The Component Programs and the Component Program Documents in their entirety are incorporated herein by reference and made a part of the Plan.

1.6 **Inconsistent Provisions in Component Program Documents**

If any provision in a Component Program Document conflicts with, contradicts, or renders ambiguous any provision in this document, the provision in this document will control unless otherwise specifically provided.

1.7 **Effect Upon Other Plans**

Except to the extent provided herein, nothing in the Plan will be construed to affect the provisions of any other plan maintained by the Employer, including a plan intended to comply with the qualification provisions of sections 401(a) and 501(a) of the Code.

1.8 **Jurisdiction**

Except to the extent ERISA or any other federal law applies to the Plan and preempts state law, the Plan will be construed, enforced, and administered according to the laws of the State of Texas.

1.9 **Severability**

If any provision of the Plan is held illegal, invalid, or unenforceable for any reason, that holding will not affect the remaining provisions of the Plan. Instead, the Plan will be construed and enforced as if the illegal, invalid, or unenforceable provision had not been included herein.

End of Article I
ARTICLE II — ESTABLISHMENT AND PURPOSE

2.1 Establishment and Purpose

The Company has adopted and established the Plan for the purpose of providing the benefits under and coordinating the administration of the Component Programs, which provide certain health, accident, life, disability, and other welfare benefits for Employees and their Dependents, where applicable.

2.2 Intention to be Welfare Benefit Plan

The Company intends the Plan to be an employee welfare benefit plan under section 3(1) of ERISA and its regulations, to the extent the benefits provided by each Component Program so permit. If any benefit provided under a Component Program is determined not to be a benefit eligible to constitute an employee welfare benefit plan under section 3(1) of ERISA, such a determination will not prevent the remainder of the Plan from qualifying as an employee welfare benefit plan within the meaning of such section. Notwithstanding the foregoing, the Dependent Day Care Spending Account Program, the cafeteria plan, and any Health Savings Account established by an HSA Eligible Participant will not be considered an employee welfare benefit plan within the meaning of section 3(1) of ERISA and the regulations (unless such a determination is required by such regulations or by other Department of Labor guidance).

2.3 Intention to be Cafeteria Plan

The Company intends the Plan to provide Employees a choice between taxable compensation (cash) and benefits with respect to the Cafeteria Component Programs. The Company intends the Plan to qualify as a “cafeteria plan” under section 125 of the Code as to the Cafeteria Component Programs. In no event will the Plan be administered or construed to constitute a plan of deferred compensation. The cafeteria-plan provisions under this Plan are intended to be severable. If the Plan is determined to be discriminatory within the meaning of section 125 of the Code, then only the Cafeteria Component Programs will be affected thereby.

End of Article II
ARTICLE III — PARTICIPATION

3.1 Commencement of Participation

Each Employee will become a Participant in the Plan coincident with the date the Employee becomes enrolled in and covered under one or more of the Component Programs. By becoming a Participant in a Component Program under the Plan, an eligible person will for all purposes be deemed conclusively to have assented to the terms and conditions of this Plan and each applicable Component Program.

3.2 Enrollment in Component Programs

Rules of eligibility, enrollment, coverage, and termination of coverage vary for each Component Program and are set forth in the respective Component Program Documents. Enrollment and coverage in a Component Program will be subject to any required premium payment applicable to such coverage and to all other terms and conditions set forth in the applicable Component Program Document.

Under each Component Program, different benefits may be provided with respect to different Employee categories or portions of such Employee categories, and neither the Plan nor the Company will be under any obligation to provide comparable benefits, in the aggregate or on a benefit-by-benefit basis, with respect to such separate Employee categories or portions of such Employee categories. Nothing in this Plan will be construed or applied to indicate that each Component Program is applicable to each Employee category hereunder, or to all persons assigned to each Employee category.

Notwithstanding any other provision of this Section 3.2 or the terms and conditions of an applicable Component Program Document, an Employee must complete any applicable enrollment forms, dependent verification forms and provide all necessary information (e.g., Social Security Numbers) required for participation in, and coverage under, a Component Program. Enrollment in a Component Program will not be effective unless and until all required forms and information have been timely provided, and may be suspended in the event that an Employee fails to provide necessary information or forms with respect to his coverage or that of an eligible Dependent, until such information or forms have been provided to the Daily Administrator.

3.3 Amending or Changing Coverage; Re-enrollment

Participants may amend or change coverage under a Component Program, or, where applicable, re-enroll in a Component Program, only when and as permitted herein or by the applicable Component Program.

3.4 Termination of Participation

Except as otherwise specifically provided by the Plan, a Participant will cease to participate in the Plan when any one of the following occurs:

(a) the date the Participant is no longer enrolled in and covered under at least one Component Program;
If a Participant ceases to participate in the Plan, he will be entitled to resume participating in accordance with Section 3.1. A transfer of employment among the Company and Participating Employers will not be considered as a termination of employment for purposes of the Plan.

3.5 Dependent Coverage

(a) **Commencement of Participation.** Each Dependent will become a Covered Dependent under the Plan coincident with the date the Dependent becomes enrolled in and covered under at least one Component Program.

(b) **Enrollment in Component Programs.** Rules of eligibility, enrollment, coverage, and termination of coverage for Dependents in a Component Program vary for each Component Program and are set forth in the respective Component Program Documents.

(c) **Termination of Participation.** Plan coverage for a Participant's Covered Dependent will terminate when any one of the following occurs:

(i) the date the Dependent is no longer enrolled in and covered by at least one of the Component Programs;

(ii) the date the Covered Dependent ceases to qualify as a Dependent;

(iii) the date the Participant ceases to be enrolled in and covered under at least one Component Program covering the Covered Dependent; or

(iv) the effective date of termination of the Plan.

If coverage for a Covered Dependent terminates, he will be entitled to resume coverage in accordance with Paragraph (a) above.

(d) **QMCSOs.** Notwithstanding Paragraphs (a), (b), and (c) above, each Component Program that is a group health plan within the meaning of section 607(1) of ERISA (i.e., the Medical Benefit Program component (includes all insured and self-funded medical benefits provided), the Dental Benefit Program component, the Vision Benefit Program component, and the Health Care Spending Account component) will comply with a “qualified medical child support order” or “QMCSO” within the meaning of section 609 of ERISA, but only to the extent required by and under the conditions specified in section 609 of ERISA. The Daily Administrator will establish such rules and procedures regarding such orders, as is required by ERISA.

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**TENET EMPLOYEE BENEFIT PLAN**

13-DAL02:513509.7
3.6 Participation While on Leave

(a) **FMLA and USERRA Leave.** To the extent required by FMLA or USERRA, a Participant may elect to continue coverage under a Health Care Component that is subject to the FMLA or USERRA, as applicable, during his leave. A Participant who elects such continuation is responsible for paying his share of the contributions for that coverage during the leave, and the Employer is obligated to pay its share during the leave. Further, to the extent permitted by the Component Program, a Participant may elect to continue all or a portion of his coverage under a contributory non Health Care Component during FMLA Leave or USERRA Leave. A Participant who desires to continue such other coverage must agree to pay his share of the contributions for such other coverage during the leave under one of the options described in this Section 3.6, to the extent such option is permitted by the terms of the Component Program, and the Employer is obligated to pay its share during the leave (unless provided otherwise in the Component Program Document).

The payment options available to a Participant during FMLA Leave or USERRA Leave are:

(i) **Paid Leave.** If the FMLA Leave or USERRA Leave is a paid leave and the Participant elects to continue his coverage, the Participant's contributions will continue to be paid by the method used prior to the leave.

(ii) **Unpaid leave.** If the FMLA Leave or USERRA Leave is an unpaid leave and the Participant elects to continue his coverage, the Participant may, to the extent permitted by the Component Program, elect to pay his contributions under any of the following options:

   (A) **Pre-pay Option.** The Participant may elect to pay his contributions prior to going on the leave. Contributions under the pre-pay option may be made on either a pre-tax or after-tax basis, as elected by the Participant.

   (B) **Pay-as-you-Go Option.** The Participant may elect to pay his contributions during the leave either on the same schedule as payments would be made if the Participant were not on leave, on the schedule applicable to COBRA premiums, or on any other schedule the Employer may establish consistent with regulations issued under the FMLA. Contributions under the pay-as-you-go option will be made on an after-tax basis.

   (C) **Catch-up Option.** The Participant may elect with the consent of the Employer, which consent will be granted on a non-discriminatory basis, to continue his benefits during the period of leave and, upon his return from the leave, to reduce his future Compensation in an amount sufficient to pay the contributions incurred during such leave. Payments under this catch-up option may be made with either pre-tax or after-tax dollars, as elected by the Participant.
With respect to Cafeteria Component Programs only, if the FMLA Leave or USERRA Leave will span two different Plan Years, the Participant may not elect the pre-pay option for that portion of the FMLA Leave or USERRA Leave that occurs during the next Plan Year; but, instead, must elect the pay-as-you-go option or catch-up option for the period of FMLA Leave or USERRA Leave during the next Plan Year. The Company will be entitled to collect premiums that a Participant fails to pay in accordance with the terms of the payment option selected by such Participant to the fullest extent permitted by law.

If a Participant elects not to continue his coverage under the Health Care Spending Account Program during an FMLA leave, then upon his return from that leave, the Participant will be given the option to either (i) resume coverage at the original level and make up the unpaid premiums or (ii) resume coverage at a reduced level in which case the Participant's coverage amount under the Health Care Spending Account Program will be adjusted to reflect the period of his FMLA leave during which he did not make contributions and his premium payments will resume at the original level.

Any continued coverage provided by the Employer pursuant to this Section in the case of a FMLA Leave will be in addition to any COBRA continuation coverage the Participant and his covered Spouse and Dependents are entitled to under section 4980B of the Code, section 609 of ERISA, and Article V of this Plan. The Participant and his covered Spouse and Dependents will be provided with notice of their COBRA rights, if any, at the end of the FMLA Leave regardless of whether they elect to continue coverage pursuant to this Section 3.6(a) during such FMLA Leave. In the case of a USERRA Leave, the Participant and his covered Spouse and Dependents will be provided notice of their COBRA rights, if any, at the earlier of the date their continued coverage under this Section ends for any reason (including a failure to pay premiums) or the end of the USERRA Leave.

Unless provided otherwise in the Component Program, any continued coverage provided by the Employer pursuant to this Section 3.6(a) during a USERRA Leave will be treated as, and count against, satisfaction of the COBRA continuation period applicable to the Participant and his covered Spouse and Dependents under section 4980B of the Code, section 609 of ERISA and Article V of this Plan. If the Participant does not elect to continue coverage pursuant to this Section 3.6(a), or elects to continue such coverage during such leave but ceases to pay his portion of the cost of such coverage during such leave, such Participant will be provided with notice of his COBRA rights if any.

(b) **Non-FMLA and Non-USERRA Unpaid Leave.** A Participant’s coverage under the Plan will continue during an approved unpaid leave of absence (that is not an FMLA Leave or USERRA Leave) to the extent provided in the Component Programs. A Participant may elect to continue coverage under a Health Care Component during such leave if allowed by the Component Program. A Participant who elects such continuation during a leave is responsible for paying the full contribution for the coverage during such leave, (unless provided otherwise in the Component Program Document). Further, to the extent permitted by the non-Health Care Components, a Participant may elect to continue all or a portion of his contributory coverage under such other programs during the leave. A Participant who desires to continue such other coverage
must agree to pay his share of the contributions for the coverage as specified in the Component Program, and the Employer will continue to pay its share for such other coverage during the leave (unless provided otherwise in the Component Program Document).

If a Component Program does not allow a Participant’s coverage to continue during an unpaid leave of absence (which does not qualify as FMLA Leave or USERRA Leave), coverage will be suspended during such unpaid leave of absence; provided, however, that the Participant and his covered Dependents (who are qualified beneficiaries within the meaning of Section 5.3) may elect, pursuant to COBRA, to continue coverage under a Health Care Component that is a group health plan within the meaning of section 5000(b)(1) of the Code or section 607(1) of ERISA (i.e., the Medical Benefit Program component (includes all insured and self-funded medical benefits provided), the Dental Benefit Program component, the Vision Benefit Program component, and the Health Care Spending Account component).

A Participant who takes a paid leave of absence will not be eligible to revoke his coverage elections pursuant to this Paragraph (b); but, instead, such coverage and the associated Salary Redirections will remain in effect for the duration of such leave. The Participant may be billed separately for such coverage during such leave.

Unless provided otherwise in the Component Program, any continued coverage provided by the Employer pursuant to this Paragraph (b) will be treated as, and count against, satisfaction of the COBRA continuation period applicable to the Participant and his covered Spouse and Dependents under section 4980B of the Code, section 609 of ERISA and Article V of this Plan. If the Participant does not elect to continue coverage pursuant to this Paragraph (b), or elects to continue such coverage during such leave but ceases to pay his portion of the cost of such coverage during such leave, the Participant will be provided with notice of his COBRA rights if any, at that time.

3.7 **Enrollment Without Regard to Medicaid or Medicare Eligibility**

Except as may otherwise be required with respect to a HIPAA special enrollment event, each Health Care Component will enroll an individual in the Plan without regard to the fact the individual is eligible for or is provided (a) medical assistance under a state plan for medical assistance approved pursuant to Title XIX of the Social Security Act, or (b) benefits under Part A or B of Medicare, to the extent such Health Care Component is required to comply with such law.

3.8 **Special Requirements for Health Care Components**

To the extent required, each Health Care Component that is a group health plan within the meaning of section 9832 of the Code (i.e., the Medical Benefit Program component, the Dental Benefit Program component, and the Vision Benefit Program component, unless such Component Programs are only providing limited scope dental and vision benefits) will operate in compliance with the applicable requirements of Subtitle K, Chapter 100 of the Code (i.e., the special enrollment and portability requirements of section 9801 of the Code, the health status nondiscrimination requirements of section
9802 of the Code, the guaranteed renewability requirements of section 9803 of the Code, the newborns and mothers protection provisions in section 9811 of the Code, and the mental health and substance use disorder provisions of section 9812 of the Code, the coverage of dependent students on medically necessary leaves of absence of section 9813 of the Code, and the applicable mandates of Health Care Reform, as amended, of section 9815 of the Code) which provisions are hereby incorporated herein by reference. Compliance with the requirements of subtitle K, chapter 100 of the Code will include, without limitation, compliance with the special enrollment rules that (a) apply in the event of a Participant’s acquisition of a new Dependent or the loss of group health plan or health insurance coverage by an Eligible Employee, Spouse, or Child and (b) permit an Eligible Employee and such Eligible Employee’s Dependent(s) to enroll in the Plan in the event that (i) such Eligible Employee’s or Dependent(s) coverage under Medicaid or a state children’s health insurance program is terminated as a result of loss of eligibility, provided that such Eligible Employee requests such enrollment within 60 days after such termination of coverage and (ii) such Eligible Employee or Dependent(s) becomes eligible for a premium assistance subsidy under Medicaid or a state children’s health insurance program, provided that such Eligible Employee requests such enrollment within 60 days after eligibility for such premium assistance subsidy is determined, effective April 1, 2009.

Each Health Care Component that is a group health plan within the meaning of section 733 of ERISA (i.e., the Medical Benefit Program component, the Dental Benefit Program component, and the Vision Benefit Program component, unless such Component Programs are only providing limited scope dental and vision benefits) will also operate in compliance with section 713 of ERISA, regarding mandated coverage of post-mastectomy reconstructive surgery, to the extent applicable.

Each Health Care Component that is a “group health plan” within the meaning of the following laws (unless such Health Care Component is providing only excepted benefits including limited scope dental and vision benefits) will comply with the requirements of such laws, to the extent that they are applicable to the Plan: GINA, Michelle’s Law, and the Mental Health Act.

Each Health Care Component that is a “group health plan” within the meaning of Health Care Reform (unless such Health Care Component is providing only excepted benefits including limited scope dental and vision benefits) will comply with the requirements of Health Care Reform as a grandfathered or non-grandfathered plan, as such terms are defined by Health Care Reform, to the extent that such requirements are applicable to the Plan.

3.9 Correction of Coverage or Enrollment Error

If the Daily Administrator or Committee determines in its discretion that an error has occurred with respect to enrollment or coverage under the Plan, the Daily Administrator or Committee may correct any such error in any manner it deems appropriate; provided, however, that, to the extent any such correction is not a permissible mid-year election change in accordance with Section 4.4 and under section 125 of the Code and results in a cost increase or decrease to the affected Participant, such Participant will not be permitted to make a corresponding change to the amount of his pre-tax contributions
elected for the Plan Year, and any increase in cost to such Participant resulting from such correction must be paid by the Participant on an after-tax basis.

End of Article III
ARTICLE IV — CAFETERIA PLAN PROVISIONS

4.1 Election of Cash or Qualified Benefits

(a) Nature of Election.

(i) **General Rule.** An Employee may elect either to (A) receive his Compensation for any Plan Year in cash, or (B) participate in one or more of the Cafeteria Component Programs and have his Compensation reduced on a pre-tax basis, with the amount of such reduction applied by the Employer toward his share of the cost of benefit coverage elected by the Employee under the Cafeteria Component Programs. In addition, the Employer may elect on a nondiscriminatory basis to provide credit dollars to Employees which may be used to purchase benefits under the Cafeteria Component Programs. A Participant may also elect to purchase coverage under the Disability Benefit Program on an after-tax basis through the Cafeteria Component Program. (After-tax contributions for any other insured benefit offered through a Component Program that is not a group health plan within the meaning of section 5000(b)(1) of the Code or section 607(1) of ERISA will be made outside of the Cafeteria Component Program.) A qualified beneficiary who elects continuation coverage under COBRA pursuant to Article V will pay the premiums for such coverage pursuant to the provisions of this Article IV on either a pre-tax or after-tax basis, as applicable. However, in no event will an Employee be allowed to elect a benefit that is offered under a Cafeteria Component Program if such benefit is not a “qualified benefit” within the meaning of section 125(f) of the Code, and any such election will be null and void. All Participants in the Cafeteria Plan must be Employees.

(ii) **Opt Out Feature.** The Employer may permit Employees who work in certain job classifications specified by the Employer to elect to receive an increase in Compensation for the Plan Year in lieu of participating in the Cafeteria Component Programs for such Year.

(b) Election Procedure. An Employee’s election to participate in a Cafeteria Component Program must be made according to the rules and procedures the Daily Administrator establishes. Such rules and procedures may include (but are not limited to) any or all of the following:

(i) Compensation reduction contributions from the last month of a Plan Year can be used to pay accident or health premiums for insurance during the first month of the immediately following Plan Year, if done on a uniform and consistent basis with respect to all Participants;

(ii) Evergreen elections are permitted for each of the Cafeteria Component Programs, including the Health Care Spending Account and the Dependent Day Care Spending Account; and

(iii) New elections and revocations or changes in elections are permitted to be made electronically.
Such Employee’s Compensation will be reduced in accordance with such election, and an amount equal to the reduction will be contributed by the Employer to cover the Employee's share of the cost of such benefit coverage under the Cafeteria Component Program.

4.2 Annual Election Procedure

(a) **Annual Enrollment.** Prior to the commencement of each Plan Year, the Daily Administrator will allow each Participant and each other Employee who will become a Participant as of the first day of the Plan Year to (i) elect to reduce his Compensation on a pre-tax basis (and to allocate any credit dollars, if applicable) in an amount equal to such Participant's share of the cost of benefit coverage elected by such Participant under the applicable Cafeteria Component Program (subject to any minimums and maximums set forth in each program which are hereby incorporated herein by this reference) or (ii) receive an increase in Compensation in lieu of participating in the Cafeteria Component Programs for such Plan Year, if applicable. Such election will become effective as of the first day of the Plan Year and remain in effect for the entire Plan Year, except as provided below. Subject to a Participant’s ability to revoke his election, as provided in Section 4.4, any Compensation reduction election will, where appropriate, be adjusted automatically in the event of a change in any such cost. The Participant must make his election pursuant to the rules and procedures established by the Daily Administrator and communicated to the Participant.

(b) **Failure to Elect.** An Employee who fails to make his election timely will be deemed to have elected to receive his full Compensation for the Plan Year in cash and will not be enrolled in any of the Cafeteria Component Programs under the Plan.

(c) **Mid-Year Election For New or Newly Eligible Employees.** As soon as practicable prior to a new Employee or a newly eligible current Employee first becoming eligible for a Cafeteria Component Program, the Daily Administrator will allow such person the opportunity to make the election described in Section 4.1. A new or newly-eligible Employee who fails to make a timely election will be deemed to have elected to receive his full Compensation for the balance of the Plan Year in cash and will not be enrolled in any of the Cafeteria Component Programs under the Plan.

(d) **Optional Retroactive Enrollments.** If a Cafeteria Component Program permits immediate entry into that Cafeteria Component Program for new hires, then the Employer may elect to implement the retroactive election period described below in this Section 4.2(d).

If elected by an Employer, a 30-day retroactive enrollment period will be permitted for new hires only. This retroactive enrollment period is not available to Employees who terminate employment and are rehired within 30 days of termination or return to employment following an unpaid leave of absence of less than 30 days. The Employer may permit elections for retroactive enrollment to relate back to the Employee’s date of hire. However, Compensation reductions
to pay for such an election must be from Compensation not yet currently available on the date of the election.

4.3 Election Changes by Daily Administrator

(a) Either prior to or during any Plan Year the Daily Administrator may, as to all or any class of Participants and under rules uniformly applicable to similarly situated Participants, change any election then in effect as to future reductions in Compensation, including a modification of elections by (a) “highly compensated participants,” as such term is defined in section 125 of the Code, (b) “key employees,” as such term is defined in section 416 of the Code, (c) “highly compensated individuals,” as such term is defined in section 105(h) of the Code, or (d) highly compensated employees or principal shareholders or owners as defined in section 129 of the Code with or without the consent of such Employees, if the Daily Administrator, in its discretion, determines that such reduction is necessary or advisable in order to satisfy the nondiscrimination requirements under provisions of the Code, including section 125 thereof, or to maintain the nontaxable status of benefits payable under the Cafeteria Component Programs.

(b) If the Daily Administrator or Committee should discover that a mistake has been made with regard to the administration of any provision of the Plan (such as determining whether or when an Employee is eligible to participate in the Plan or executing annual or special elections made by a Participant), the Daily Administrator or Committee may take such administrative action as it deems necessary or appropriate to remedy the mistake in question, including but not limited to allowing participation in the Plan, providing for catch-up contributions, or modifying enrollment elections. Any such administrative action will conform to the requirements of section 125 of the Code and the regulations issued thereunder.

4.4 Election Revocation and Changes by Participants During the Plan Year

(a) General Rule. Except as otherwise provided in this Section 4.4, a Participant may not revoke or change his election during a Plan Year. Similarly, an eligible Employee who has elected not to participate in the Plan for a Plan Year may not change his election during such Plan Year (except as provided in this Section 4.4).

(b) Changes in Status. To the extent provided in the Component Programs, a Participant may revoke or modify his election for the balance of the Plan Year only if such revocation or modification is on account of and consistent with a Major Life Event. If such revocation or modification is on account of and consistent with a Major Life Event, the Participant may make a new election for the remaining portion of the Plan Year; provided, however, that the new election must be on account of and consistent with the Major Life Event. A Participant desiring to revoke or modify an election and, if applicable, to file a new election will so advise the Daily Administrator within the time and manner prescribed by the Daily Administrator. However, (i) a Major Life Event on account of special enrollment rights under section 9801(f) of the Code (which apply in the event of
the Participant's acquisition of a new Dependent or the loss of group health plan or health insurance coverage by the Employee, Spouse, or Child) need not satisfy the above consistency requirements; and (ii) with respect to a Component Program that provides life insurance benefits, an election to increase or decrease coverage is deemed to correspond with such Major Life Event.

(c) Cost or Coverage Changes. To the extent provided in the Component Programs or by the Daily Administrator, a Participant may file an election with the Daily Administrator to revoke or modify (subject to the conditions below) any prior election and/or to make a new election with respect to the remaining portion of a Plan Year as each separate Component Program (other than the Health Care Spending Account) may allow on account of (i) a significant increase or decrease in the cost of coverage, (ii) an improvement or addition of a coverage option, or (iii) a significant curtailment in the coverage provided under a Component Program as follows:

(A) Cost Changes. If the cost of a Participant's portion of coverage under a Component Program increases or decreases during the Plan Year, such Participant's Compensation reductions will automatically be increased or decreased on a prospective basis, as applicable; provided, however, that if the increase or decrease is significant, the Participant may make an election as described in the next sentence. If the cost of a Component Program significantly increases or decreases during a period of coverage, a Participant may prospectively increase payments, decrease payments, or revoke his election and, in lieu thereof, elect to receive on a prospective basis coverage under another Component Program option providing similar coverage. If no other Component Program option that provides similar coverage exists, the Participant may be permitted to revoke coverage altogether on account of a significant increase or decrease in the cost of coverage. The determination of whether a cost increase or decrease is "significant" will be made by the Daily Administrator.

(B) Coverage Changes. If the coverage under a Component Program is significantly curtailed or a new Component Program or coverage option is added during the Plan Year, a Participant may file a written election with the Daily Administrator to make the following election changes.

(1) Significant curtailment without loss of coverage. If a Participant has a significant curtailment of coverage during the Plan Year that is not a loss of coverage, such as a significant increase in the deductible, the co-pay or the out-of-pocket cost sharing limit under a Health Care Component Program that is also a Cafeteria Component Program, any Participant who is participating in the Plan and receiving that coverage may revoke his election for that coverage and make a new election on a prospective basis under a Component Program option providing similar
coverage. The determination of whether a significant curtailment has occurred will be made by the Daily Administrator. However, coverage under the Medical Benefit Program will be significantly curtailed only if there is an overall reduction in coverage provided to Participants generally. Accordingly, in most cases, the loss of one particular physician in a network does not constitute a significant curtailment.

(2) **Significant curtailment with loss of coverage.** If a Participant has a significant curtailment of coverage during the Plan Year that is a loss of coverage, the Participant may revoke his election and on a prospective basis elect either to receive new coverage under another Component Program coverage option providing similar coverage or to drop coverage if no similar Component Program coverage option is available. For this purpose, a loss of coverage means a complete loss of coverage under a Component Program or coverage option (including the elimination of a Component Program coverage option, an HMO ceasing to be available where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual maximum). In addition, the following events will also constitute a loss of coverage: (a) a substantial decrease in the medical care providers available under a coverage option under the Medical Benefit Program; (b) a reduction in the benefits for a specific type of medical condition or treatment with respect to a Participant (or enrolled Dependent) currently in that course of treatment; or (c) any other similar fundamental loss of coverage.

(C) **Addition or improvement of benefit package option.** If the Plan adds a new Component Program coverage option or Component Program, or if coverage under an existing Component Program or coverage option is significantly improved during a period of coverage, an eligible Employee (whether or not he has previously made an election under the Plan or has previously elected the Component Program option) may revoke his election under the Plan and elect the newly added or improved Component Program option. For example, if a new HMO option is added as a Medical Benefit Program coverage option during the Plan Year, the Plan may allow eligible Employees to elect that option or any existing Medical Benefit Program option provided through the Plan. Conversely, if the eligible Employee had previously made an election under the Plan, then the eligible Employee may only elect to revoke his coverage and elect the same type of coverage (i.e., “Employee only” or family coverage) under the Medical Benefit Program option. For example, if prior to the beginning of the Plan Year, an eligible Employee elects “Employee plus one” coverage under an indemnity plan coverage option provided under the
Medical Benefit Program and during the year the Company adds an HMO option that provides “Employee only” or family coverage, the eligible Employee may elect to revoke his election for indemnity coverage and elect family coverage under the HMO option on a prospective basis. The eligible Employee could not, however, elect “Employee only” coverage under the HMO option because that election would not be consistent with the addition of the HMO option since prior to such date the eligible Employee had “Employee plus one” coverage.

(d) **FMLA or USERRA Leave.** To the extent provided in a Component Program, a Participant may revoke his election for the balance of the Plan Year upon his taking FMLA Leave or USERRA Leave. In addition, a Participant upon his taking of or returning from, or during his, FMLA Leave or USERRA Leave may modify or revoke his election in accordance with the Major Life Event rules in Paragraph (b), above.

(e) **Medicare or Medicaid Entitlement.** A Participant may file an election with the Daily Administrator to revoke or modify any prior election and/or to make a new election with respect to the remaining portion of a Plan Year as each separate Component Program may allow on account of entitlement to Medicare or Medicaid (other than coverage solely for pediatric vaccines). Likewise, a Participant may file an election with the Daily Administrator to revoke or modify any prior election and/or to make a new election with respect to the remaining portion of a Plan Year as each separate Component Program may allow on account of the loss of entitlement to Medicare or Medicaid.

(f) **Judgment, Decree or Order.** If a judgment, decree or order resulting from divorce, legal separation, annulment or a change in legal custody (including a QMCSO) requires accident or health coverage of an Employee’s Dependent Child, the Employee may change his election to (i) add coverage for the Employee and/or the Dependent Child under the Medical Benefit Program if the order requires or (ii) cancel Medical Benefit Program coverage for the Dependent Child if the order requires the Spouse, former Spouse or someone else to provide coverage for the Child; provided, however, that the Employee will not be permitted to revoke coverage for the Child unless he provides proof of such alternate coverage.

(g) **Effective Date of Revocation or Change.** The Daily Administrator will review an Employee’s or Participant’s request to revoke or modify his election and will determine if the Participant has met the requirements of Paragraphs (b), (c), (d), (e), or (f) above. Except as the Daily Administrator may otherwise provide by rule or regulation, the Daily Administrator will approve an Employee’s or Participant’s request to revoke or modify his election only if the request is received by the Daily Administrator no later than 31 days after the occurrence of the reason therefore.

(h) **Health Savings Account Contributions.** Notwithstanding any provision of this section 4.4 or the Plan to the contrary, the following special rules apply to an HSA Eligible Participant:
(i) Subject to the limitations of section 223 of the Code, each HSA Eligible Participant may, at any time during the Plan Year, prospectively change his or her election with regard to Employee contributions to such HSA (and only such contributions), and such election change will be effective as of the first day of the first administratively practicable pay period coincident with or next following the date such request for an election change is completed and filed with the Daily Administrator.

(ii) Subject to the limitations of section 223 of the Code, any Participant who ceases to be an HSA Eligible Participant may, at any time during the Plan Year, prospectively revoke his or her existing election with regard to his or her HSA contributions (and only such contributions), and any such revocation will be effective on the first day of the first administratively practicable pay period coincident with or next following the date the revocation request is completed and filed with the Daily Administrator.

(i) **Component Programs Control.** A Participant will not be permitted to revoke an existing election and/or file a new election to the extent such revocation or filing conflicts with the terms of the applicable Component Program.

4.5 **Automatic Termination of Election**

A Participant's election with respect to a Cafeteria Component Program will automatically terminate on the date on which the Participant ceases to be a Participant in that program; however, coverage or benefits under that program may continue if and to the extent provided therein.

4.6 **Maintenance of and Adjustments to Spending Accounts**

(a) **Establishment of Spending Accounts.** The Daily Administrator will maintain separate accounts for each Participant who elects to participate in either (or both) of the Spending Accounts in accordance with Section 4.1. Likewise, the Daily Administrator will establish a separate account for each Participant who continues COBRA coverage under the Health Care Spending Account Program as provided pursuant to Section 5.10. Each such separate account will be credited and charged only with those credits and charges attributable to such account as specified herein and in the Spending Accounts. A credit or debit balance in any one such account may not be used to credit or debit any other such account, and each such account will be administered separately. No interest will be credited to or accrue on any balance in such accounts.

(b) **Credits.** Each month or part thereof during which a Participant has an account pursuant to Paragraph (a), such account will reflect: (i) any credit thereto as of the close of the prior month, plus (ii) the amount credited thereto during such month in accordance with the Spending Accounts.

(c) **Debits.** Each month, the value of any benefits paid to or on behalf of a Participant, Spouse, or Dependent under a Spending Account Program will be charged against such Participant's account for that program, and will reduce his balance in that account.
(d) **Forfeiture.** Any credit balance remaining in such an account as of the end of a Plan Year will be forfeited and applied in accordance with the provisions of the applicable Spending Account Program.

(e) **Substantiation.** All claims will be substantiated in accordance with the Code section 125 and the regulations thereunder prior to payment or reimbursement of expenses for “qualified benefits.”

### 4.7 Limitation of Article

This Article IV applies only to the Cafeteria Component Programs.

End of Article IV
ARTICLE V — COBRA

5.1 Continuation of Coverage

(a) **General Rule.** Subject to the provisions of this Article V, each “qualified beneficiary” who would “lose coverage” under a Health Care Component that is a group health plan within the meaning of section 5000(b)(1) of the Code or section 607(1) of ERISA (i.e., the Medical Benefit Program component (includes all insured and self-funded medical benefits provided), the Dental Benefit Program component, the Vision Benefit Program component, and the Health Care Spending Account component) as a result of a “qualifying event” will be entitled to elect, within the “election period,” continuation of coverage under that Health Care Component. The foregoing terms in quotations are defined below.

(b) **Coverage.** In Paragraph (a), “coverage” means coverage that—as of the time coverage is being provided—is identical to the coverage provided under the Health Care Component to similarly situated beneficiaries under the Health Care Component who have not had a qualifying event. If coverage under the Health Care Component is modified for any group of similarly-situated beneficiaries, coverage under this Article V will likewise be modified for all individuals who are similarly-situated qualified beneficiaries under that Health Care Component. Further, if there is a choice among coverage options available to participants in the Health Care Component, this choice will be offered to each qualified beneficiary. Continuation of coverage will not be conditioned upon—nor discriminate on the basis of lack of—evidence of insurability or medical underwriting.

5.2 Qualifying Event and Loss of Coverage

(a) **Qualifying Event.** In this Article, the term “qualifying event” means, with respect to a Participant, any of the following events that—if not for the continuation of coverage required under Section 5.1—would cause a qualified beneficiary to “lose coverage” under a Health Care Component:

(i) Death of the Participant;

(ii) Termination of the Participant’s employment (other than for the Participant’s gross misconduct) or reduction in hours of service of the Participant's employment;

(iii) Divorce or legal separation of the Participant from his or her Spouse;

(iv) Entitlement by the Participant to Medicare benefits;

(v) A Child ceasing to qualify as such under the terms of the Plan; or

(vi) A bankruptcy proceeding in a case under Title 11 of the United States Code, commencing on or after July 1, 1986, with respect to the Employer from whose employment a Participant retired at any time. For purposes of the foregoing, a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary described in Section
5.3(a)(ii) within one year before or after the date of commencement of the bankruptcy proceeding in a case under Title 11 of the United States Code. For purposes of this Paragraph and all provisions of Article V applicable to this Paragraph, “Participant” means an individual who is a retiree of the Employer and is (or was) provided coverage under the Plan because he worked for the Employer.

(b) **Loss of Coverage.** In this Article V, to “lose coverage” means to cease to be covered under the same terms and conditions as in effect immediately prior to the qualifying event. If coverage is reduced or eliminated in anticipation of an event, the reduction or elimination is disregarded in determining whether the event causes a loss of coverage. Moreover, a loss of coverage need not occur immediately after the event, so long as the loss of coverage will occur prior to the end of the coverage period described in Section 5.7. For purposes of an FMLA Leave, the loss of coverage and the qualifying event occur on the last day of the FMLA Leave, even if the Participant did not maintain coverage under the Health Care Component during the FMLA Leave; provided, however, that if coverage extends beyond the end of the FMLA Leave, then the qualifying event occurs at the time of the actual loss of coverage.

### 5.3 Qualified Beneficiaries

(a) **General Rule.** In this Article V, the term “qualified beneficiary” means:

1. Any individual who (A) was a Participant or a Covered Dependent of a Participant under a Health Care Component on the day before the qualifying event or (B) is a child born to or placed for adoption with the Participant during the period of the Participant's continuation of coverage under this Article V; and

2. For a qualifying event that is the bankruptcy of the Employer as described in Section 5.2(a)(vi), a Participant who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, was a Covered Dependent of the Participant.

(b) **Exclusions.** The term “qualified beneficiary” will not include (i) a Participant whose status as an eligible Employee is attributable to a period in which he was a nonresident alien and received from the Employer no earned income (within the meaning of section 911(d)(2) of the Code) constituting income from sources within the United States (within the meaning of section 861(a)(3) of the Code), (ii) a Covered Dependent of a Participant described in clause (i) above, or (iii) a Covered Dependent who is a Domestic Partner.

### 5.4 Notice Requirements

(a) **Initial Notice of COBRA Rights.** The Daily Administrator will provide, at the time of commencement of coverage under a Health Care Component, written notice to each Participant and his Covered Dependents, if any, of the rights provided under this Article V. Such notice will be provided not later than the earlier of (i) 90 days after coverage under the Plan begins, or (ii) the first date on
which the Daily Administrator is required to provide the Participant or Covered Dependent with notice of the right to elect to continue coverage under the Plan on account of the occurrence of a qualifying event. Further, in any case where the Daily Administrator is required to provide notice of the right to elect continuation coverage as described in (ii), the furnishing of the notice of the right to elect continuation coverage under Section 5.4(d) will be deemed to satisfy the requirements of this Section 5.4(a).

(b) **Employer Notice of Qualifying Event.** The Employer will notify the Daily Administrator of a qualifying event as described in Section 5.2(a)(i), (ii), (iv), or (vi) (respectively, the Participant’s death, termination of employment or reduction in hours, or entitlement to Medicare, or the bankruptcy of the Employer) within 30 days of the later of (i) the date of the qualifying event or (ii) the date coverage under the Plan is lost as a result of the qualifying event.

(c) **Participant or Qualified Beneficiary Notice.** Each Participant or qualified beneficiary must notify the Daily Administrator in writing of the occurrence of any qualifying event that is a divorce, legal separation, or loss of dependent status, as described in Section 5.2(a)(iii) or (v), or the occurrence of a second qualifying event that would increase the duration of continuation coverage from 18 or 29 months to 36 months within 60 days of the later of (i) the date of the qualifying event, (ii) the date the qualified beneficiary would lose coverage because of the qualifying event, or (iii) the date the qualified beneficiary is informed through the distribution of a summary plan description or general notice of the responsibility to provide such notice to the Daily Administrator and the Plan’s procedures for doing so. If this notice of qualifying event is not so provided, the qualified beneficiary will lose his right to elect such continuation of coverage. For purposes of the foregoing, if more than one qualified beneficiary would lose coverage on account of the divorce or legal separation of a Participant or the occurrence of a second qualifying event, a timely written notice of the divorce or legal separation or second qualifying event that is provided by the Participant or by any one of such qualified beneficiaries will be sufficient to preserve the election rights of the Participant and all such beneficiaries.

Each qualified beneficiary, who is determined under Title II or XVI of the Social Security Act to have been disabled (1) at the time of the qualifying event described in Section 5.2(a)(ii), or (2) within 60 days of such qualifying event (or, in the case of a newborn or recently adopted child of the Participant, within 60 days of the date of birth or placement for adoption), is responsible for notifying the Daily Administrator in writing of the determination before the end of the initial 18 month continuation period and within the date that is 60 days after the latest of (A) the date of such disability determination, (B) the date of the qualifying event, (C) the date the qualified beneficiary would lose coverage because of the qualifying event, or d. the date the qualified beneficiary is informed through the distribution of a summary plan description or a general notice of the responsibility to provide such notice to the Daily Administrator and the Plan’s procedures for doing so. The qualified beneficiary is also responsible for notifying the Daily Administrator in writing of a final determination that the qualified beneficiary is no longer disabled under such titles within 30 days after the later of (x) the date of such determination or (y) the date that the qualified beneficiary is informed.
through the distribution of a summary plan description or a general notice of the responsibility to provide such notice to the Daily Administrator and the Plan's procedures for doing so.

(d) **Daily Administrator Notice of Rights to Elect Continuation Coverage.** Upon receipt of the notice by the Employer described in Section 5.4(b) (regarding a qualifying event which is, respectively, the Participant's death, termination of employment or reduction in hours, or entitlement to Medicare, or the bankruptcy of the Employer), or upon receipt of the notice from the Participant or qualified beneficiary described in Section 5.4(c) (regarding an initial qualifying event which is, respectively, divorce or legal separation, or loss of dependent status or a second qualifying event), the Daily Administrator will notify any qualified beneficiary of the right to elect COBRA continuation coverage with respect to such qualifying event. This notice will be given to the qualified beneficiary within 14 days of the date on which the Daily Administrator is notified under Section 5.4(b) or (c), whichever is applicable, and will contain the information required by Labor Regulation section 2590.606-4(b)(4). Any such notice to an individual who is a qualified beneficiary as the Spouse of the Participant will be treated as notice to all other qualified beneficiaries who are minors residing with that Spouse at the time the notice is given.

(e) **Daily Administrator Notice of Unavailability of COBRA.** If the Daily Administrator receives notice from a Participant or qualified beneficiary of a qualifying event pursuant to Section 5.4(c) above and determines that such Participant or qualified beneficiary is not entitled to continuation coverage under COBRA, the Daily Administrator will notify the Participant or qualified beneficiary that COBRA continuation coverage is not available and the reasons why. Such notice of the unavailability of COBRA continuation coverage will be provided within 14 days after the Daily Administrator receives notice of the qualifying event pursuant to Section 5.4(c) above.

5.5 **Election Requirements**

(a) **Election Period.** The term "election period" means the period that begins on the date coverage terminates under the Health Care Component due to a qualifying event and ends 60 days after the later of (i) the date on which coverage terminates under the Health Care Component due to the qualifying event or (ii) the date the qualified beneficiary is sent the notice required under Section 5.4(d). Notwithstanding Section 20.7 (regarding notice and filing), an election of continuation coverage will be deemed made when sent by the qualified beneficiary. An election of continuation coverage made during the election period is retroactive to the date of the qualifying event. If a qualified beneficiary waives his right to elect continuation coverage, the waiver may be revoked by the qualified beneficiary at any time during the election period; provided, however, that if a qualified beneficiary revokes his waiver, continuation coverage will not be provided for any period prior to the waiver.

(b) **Nature of Election.** Each qualified beneficiary (including a child who is born to or placed for adoption with a Participant receiving continuation coverage under this Article V) will be offered the opportunity to make an independent election of
continuation coverage under this Article V. However, except as otherwise specified in an election, any election of continuation coverage that is made by a qualified beneficiary who is the Participant or a Spouse of the Participant and that does not specify whether the election is for self-only coverage will be deemed to include an election of continuation on behalf of any other qualified beneficiary who would lose coverage under the Health Care Component due to the qualifying event. If there is a choice among types of coverage under the Health Care Component, each qualified beneficiary is entitled to make a separate selection among the types of coverage.

5.6 Cost of Coverage

(a) **Responsible Party.** A qualified beneficiary who elects continuation coverage under this Article V will be solely responsible for paying the full cost of such continued coverage. Payment is considered made when it is sent to the proper party. The Employer will not be obligated to contribute to the cost of continuation coverage. Payment of any initial premium by or on behalf of a qualified beneficiary will not be required until 45 days after the date continuation coverage is elected and will cover the cost of coverage for the period from the date of the qualifying event.

(b) **Amount.** The cost of continuation coverage will be determined by the Daily Administrator and will not exceed 102 percent of the cost to the Health Care Component for the same period of coverage for other similarly-situated individuals who have not experienced a qualifying event; provided, however, that if an 18-month period of coverage is extended to 29 months for the disabled qualified beneficiary pursuant to Section 5.7(a)(i)(B), any reference in this Paragraph (b) to 102 percent is deemed a reference to 150 percent for each month after 18 months with respect to the disabled qualified beneficiary and any other related qualified beneficiaries extending their coverage. Note, however, that if the disabled qualified beneficiary does not elect continuation beyond 18 months, then the cost for any other related qualified beneficiaries who do elect coverage beyond 18 months remains 102 percent and may not be increased to 150 percent. At the election of the payor, the cost of continuation coverage may be paid in monthly installments. If timely payment of such cost is made in an amount not significantly less than the amount required, then the amount paid will be deemed to satisfy the amount required, unless the qualified beneficiary is notified of the amount of the deficiency and is given a reasonable time not less than 30 days after the date of the notice in which to pay the deficiency.

(c) **Source of Payment.** Premiums for continuation coverage will be paid with after-tax dollars pursuant to the cafeteria plan provisions of this Plan, except to the extent permitted by applicable law and the Plan's administrative procedures.

5.7 Period of Coverage

(a) **General Rule.** Except as provided in Section 5.10, continuation coverage will extend for the period beginning on the date of the qualifying event and ending:
For a qualifying event that is a termination or reduction in hours as described in Section 5.2(a)(ii), 18 months after the qualifying event, unless:

(A) a qualifying event (other than a qualifying event that is a bankruptcy of the Employer as described in Section 5.2(a)(vi)) occurs during the 18-month period, in which case coverage will end 36 months after the qualifying event described in Section 5.2(a)(ii) with respect to all qualified beneficiaries except the Employee, or

(B) the qualified beneficiary is determined under Title II or Title XVI of the Social Security Act to have been disabled either at the time of a qualifying event described in Section 5.2(a)(ii) or at any time during the first 60 days of continuation coverage, in which case reference to 18 months in this Clause (i) is deemed a reference to 29 months with respect to all related qualified beneficiaries, but only if the disabled qualified beneficiary (or any related qualified beneficiary) has provided notice of the determination as required by Section 5.4(c) before the end of the first 18 (not 29) months of continuation coverage and within 60 days of the Social Security disability determination;

(ii) For a qualifying event not described in Section 5.2(a)(ii) (regarding termination or reduction in hours) or (vi) (regarding bankruptcy), 36 months after the qualifying event with respect to all qualified beneficiaries except the Employee; and

(iii) For a qualifying event that is a bankruptcy of the Employer as described in Section 5.2(a)(vi);

(A) when the Participant or the qualified beneficiary who is the surviving Spouse of the Participant dies, or

(B) for the surviving Spouse or surviving Children of the Participant, 36 months after the Participant dies.

(b) Special Rule for Medicare Entitlement. For an event described in Section 5.2(a)(iv) (without regard to whether the event is a qualifying event), the period of coverage for qualified beneficiaries other than the Participant will not terminate before the end of the 36-month period beginning when the Participant becomes entitled to Medicare benefits. In addition, in the case of a qualifying event that is the termination or reduction in hours of the Employee, the Employee's subsequent entitlement to Medicare will not constitute a second qualifying event unless becoming covered by Medicare would have caused the Employee to lose active employee coverage under the Plan.
5.8 Termination of Coverage

(a) Date of Termination. Continuation coverage for a qualified beneficiary will terminate prior to the period of coverage described in Section 5.7 when any one of the following occurs:

(i) The Employer—and all entities that are members of a group that is described in section 414(b), (c), (m), or (o) of the Code and that includes the Employer—cease to provide any group health plan within the meaning of section 5000(b)(1) of the Code or section 607(1) of ERISA;

(ii) Coverage ceases under the Health Care Component due to a failure to pay any premium required under the Health Care Component within the latest of (A) 30 days after the date due, (B) the last date a Participant is permitted to make any required contribution under the terms of that program, or (C) if applicable, the last date the Employer is permitted to pay for coverage of similarly-situated Participants under the terms of a contract between the Employer and any Insurer, HMO, PPO, or other entity that provides group-health benefits on behalf of the Employer;

(iii) The qualified beneficiary first becomes covered under any other group health plan within the meaning of section 5000(b)(1) of the Code or section 607(1) of ERISA of an employer other than the Employer, provided that such coverage does not begin on or before the date on which continuation coverage is elected;

(iv) For a qualified beneficiary who is entitled to 29 months of continuation coverage on account of disability and for all related qualified beneficiaries, the earlier of (A) the first day of 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 disabled qualified beneficiary is no longer disabled, or (B) the end of the original 18-month continuation period specified in Section 5.7(a)(i); or

(v) The qualified beneficiary (other than a qualified beneficiary described in Section 5.3(a)(ii) (regarding bankruptcy)) first becomes entitled to and enrolled in Medicare, provided the qualified beneficiary does not first become entitled to and enrolled in Medicare on or before the date continuation coverage is elected. Also, such entitlement to Medicare may constitute a second qualifying event for qualified beneficiaries other than the Employee.

(b) Notification of Termination. The Daily Administrator will notify a COBRA Beneficiary that continuation coverage of the COBRA Beneficiary or any person enrolled pursuant to Section 5.9(a) has terminated under the provisions of this Section 5.8, and of the effective date of such termination. The notice must also advise the COBRA Beneficiary of any rights to other group health coverage that are available upon the termination of coverage pursuant to this Article V. The notice will be provided as soon as administratively feasible after the date of termination.
5.9 Rights and Obligations of COBRA Beneficiary

(a) Enrollment of Dependents. Each qualified beneficiary who becomes a COBRA Beneficiary will be entitled to enroll each family member who would qualify as his Spouse, Domestic Partner, Child, or other Dependent, subject to the same terms and conditions for enrollment of Dependents set forth in the applicable Health Care Component generally; provided, however, that persons enrolled pursuant to this Paragraph (a) are not themselves eligible to become qualified beneficiaries within the meaning of Section 5.3.

(b) Other Rights. Except as otherwise specifically provided in the Plan, each individual who becomes a COBRA Beneficiary pursuant to this Article V will have the same rights and obligations as those provided to Participants and Covered Dependents under the terms of the Plan, including those regarding enrollment, amendment, termination or change of coverage, coordination of benefits, subrogation, claims procedure and review, and provision of information.

5.10 Applicability of Article

This Article V will apply only to a Participant or Covered Dependent who, or to a Health Care Component that is a group health plan within the meaning of section 5000(b)(1) of the Code or section 607(1) of ERISA (i.e., the Medical Benefit Program component (includes all insured and self-funded medical benefits provided), the Dental Benefit Program component, the Vision Benefit Program component, and the Health Care Spending Account component) which, is subject to or entitled to the continuation of coverage provisions of COBRA pursuant to section 4980B of the Code or sections 601 through 608 of ERISA.

Moreover, this Article V will only apply to the Health Care Spending Account Program for the balance of the Plan Year in which the qualifying event occurred, and even then only to the extent the maximum benefit available to the Participant at the time of the qualifying event for the remainder of the Plan Year is not more than the maximum amount the Health Care Spending Account Program could require as payment to maintain coverage for the remainder of the Plan Year.

Notwithstanding any provision of the Plan to the contrary, this Article V will only apply with respect to a Health Care Component subject to COBRA that does not contain its own COBRA procedures or to the extent that the COBRA procedures contained within such Health Care Component fail to address or ambiguously address a particular issue.

5.11 Statutory Conflict

This Article V will be administered in the manner required by COBRA and the regulations issued thereunder. In the event that there is a discrepancy between the provisions of this Article V and COBRA or the regulations issued thereunder, such discrepancy will be resolved to give full effect to the provisions of COBRA and/or such regulations.

End of Article V
ARTICLE VI — HEALTH CARE SPENDING ACCOUNT

6.1 Establishment of Plan

This Article VI constitutes a separate Health Care Spending Account that is intended to qualify as a medical reimbursement plan under section 105 of the Code and will be interpreted in a manner consistent with such Code section and the Treasury regulations thereunder. Participants who elect to participate in this Health Care Spending Account may submit claims for the reimbursement of Medical Expenses.

The term “Medical Expenses” means any expense for medical care within the meaning of the term “medical care” or “medical expense” as defined in section 213 of the Code and the rulings and Treasury regulations thereunder, and not otherwise reimbursed by insurance or used by the Participant as a deduction in determining his tax liability under the Code. However, a Participant may not be reimbursed for (i) the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent, (ii) an over-the-counter medicine or drug (except for insulin) unless a prescription (as such term is defined in Internal Revenue Service Notice 2010-59 or subsequent guidance) has been obtained for the over-the-counter medicine or drug, or (iii) “qualified long-term care services” as defined in section 7702B(c) of the Code.

6.2 Limitation on Allocations

Either the Daily Administrator or the Component Program Document may specify a minimum and maximum amount that may be allocated to the Health Care Spending Account by a Participant in or on account of any Plan Year. Any such minimum or maximum will be set forth in the Annual Enrollment materials, which are hereby incorporated by reference.

6.3 Nondiscrimination Requirements

It is the intent of this Health Care Spending Account not to discriminate in favor of highly compensated individuals or participants within the meaning of section 105 of the Code. If the Daily Administrator deems it necessary to avoid discrimination under this Health Care Spending Account, it may, but will not be required to, reject any elections or reduce contributions or benefits in order to assure compliance with this Section 6.3. Any act taken by the Daily Administrator under this Section 6.3 will be carried out in a uniform and nondiscriminatory manner. Contributions which are not utilized to provide benefits to any Participant by virtue of any administrative act under this paragraph will be forfeited.

6.4 Coordination With Cafeteria Component Program

Those Employees specified in the Health Care Spending Account Component Program Document will be eligible to elect to participate in the Cafeteria Component Program and receive benefits under this Health Care Spending Account. The enrollment under the Cafeteria Component Program will constitute enrollment under this Health Care Spending Account. In addition, other matters concerning contributions, elections and the like will be governed by the general provisions of the Plan and the Health Care Spending Account Component Program Documents.
6.5 Health Care Spending Account Claims

(a) **Reimbursement of Medical Expenses.** All eligible Medical Expenses incurred by a Participant will be reimbursed from his Health Care Spending Account, even if the submission of such a claim occurs after his participation under the Health Care Spending Account ceases if the Participant timely files for reimbursement as described in (c) below and the Medical Expenses were incurred during the applicable Plan Year and during the portion of such Plan Year as permitted herein. In general, a claim is incurred when the care is provided. A Participant’s Compensation reductions and election to participate in the Health Care Spending Account will automatically terminate as of the end of the month in which the last payroll period for which the Participant is paid ends.

(b) **Maintain Account Balance Available.** The Daily Administrator will direct the reimbursement to each eligible Participant for all eligible Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Care Spending Account for the Plan Year. Reimbursements will be made available to the Participant throughout the year without regard to the amount of contributions which have been allocated to the fund at any given point in time. Furthermore, a Participant will be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan or insurance policy covering the Participant and/or his Spouse or Dependents.

(c) **Claim Filing Deadline.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year must be filed by March 31 of the Plan Year following the Plan Year in which the expenses were incurred unless specified otherwise in the Component Program Documents. Eligible Medical Expenses properly submitted for payment will be paid as soon administratively possible after the claim has been filed.

The Committee, in its sole discretion, will determine how forfeitures are allocated, from among the following options: (a) retained by the Employer, (b) used to defray expenses of administering the Cafeteria Component Program; (c) used to reduce Compensation reduction amounts for the immediately following Plan Year, or (d) returned to Employees on a reasonable and uniform basis (but not based on individual claims experience). If not retained by the Employer or used to defray expenses of administering the Cafeteria Component Program, the forfeitures will be allocated among Employees on a reasonable and uniform basis.

(d) **Manner of Payment.** Reimbursement payments under this Health Care Spending Account will be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider.

(e) **Substantiation.** All claims must be substantiated in accordance with this section or the terms of the Component Program documents prior to payment or reimbursement of any Medical Expenses. In general, all claims must be substantiated by information from a third-party that is independent of the Employee and his Dependents. In addition, all claims must set forth:
• the person(s) on whose behalf the Medical Expense was incurred;
• the nature and date of the expenses so incurred;
• the amount of the requested reimbursement;
• the name of the person, organization or entity to whom the expense was or is to be paid and taxpayer identification number;
• a statement that such expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;
• other such details about the expenses that may be requested by the Daily Administrator on the reimbursement request form or otherwise.

The application will be accompanied by those documents listed above from an independent third party, along with any other documentation that the Daily Administrator may request (for instance, an EOB which contains all necessary information). There can be no self-substantiation of an expense by a Participant (i.e., cancelled checks to a doctor are not sufficient, standing alone).

End of Article VI
ARTICLE VII — DEPENDENT DAY CARE SPENDING ACCOUNT

7.1 Establishment of Account

This Article VII constitutes a separate Dependent Day Care Spending Account that is intended to qualify as a dependent care assistance program under section 129 of the Code and will be interpreted in a manner consistent with such Code section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Day Care Expenses. All amounts reimbursed under this Dependent Day Care Assistance Program will be paid from amounts allocated to the Participant's Dependent Day Care Spending Account.

For purposes of this Article VII, the term "Employment-Related Dependent Day Care Expenses" means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under section 21(b)(2) of the Code. Generally, they will include expenses for household services for the care of a Qualifying Individual (as defined in this Article VII) or for household services in and about the Participant's home of ordinary and usual services necessary to the maintenance of the household and attributable to the care of the Qualifying Individual, to the extent that such expenses are incurred to enable the Participant and his spouse (if any) to be gainfully employed for any period for which there are one or more Qualifying Individuals with respect to such Participant. There must be appropriate substantiation that the expense is employment-related (see Section 7.5(e)). The determination of whether an amount qualifies as an Employment-Related Dependent Day Care Expense will be made subject to the following rules:

(a) If such amounts are paid for expenses incurred outside the Participant's household, they will constitute Employment-Related Dependent Day Care Expenses only if incurred for (i) a Qualifying Individual who is a qualifying child under age 13 or (ii) the care of any other Qualifying Individual (a qualifying child age 13 or over, a qualifying relative or spouse, each of whom must be incapable of self-care and who has the same principal place of abode as the Participant for more than one-half of the year) who regularly spends at least 8 hours per day in the Participant's household;

(b) If the expense is incurred outside the Participant's home at a facility that provides care for more than 6 individuals who do not regularly reside at the facility and that receives a fee, payment or grant for such services (regardless of whether the facility is operated for profit), the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any;

(c) Employment-Related Dependent Day Care Expenses of a Participant will not include amounts paid or incurred to (i) a child (within the meaning of Code section 152(f)(1)) of such Participant who is under the age of 19 at the close of the taxable year in which the services are performed, (ii) an individual who is a dependent of such Participant or such Participant's Spouse for whom a personal exemption is allowed under Code section 151(c), (iii) a Participant's Spouse, or (iv) a parent of a Participant's under age 13 qualifying child (as defined in Code section 152(a)(1)); and
Employment-Related Dependent Day Care Expenses will not include expenses for which the Participant is reimbursed for the expense through insurance or any other plan.

A “Qualifying Individual” means (i) a tax dependent of a Participant as defined under Code section 152, who is the Participant’s qualifying child (as defined in Code section 152(a)(1)) and who has not attained age 13, (ii) a tax dependent of a Participant, as defined under Code section 152 (a qualifying child or qualifying relative), but determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof (which include certain exceptions to the definition of dependent and a gross income limitation), who (A) is physically or mentally incapable of self care and (B) has the same principal place of abode as the Participant for more than half of the year or (iii) a Participant’s Spouse who meets (A) and (B) above. Whether an individual is a Qualifying Individual is determined on a daily basis. A special rule applies for certain parents who are divorced, separated or living apart.

7.2 Limitation on Allocations

Amounts paid from a Participant’s Dependent Day Care Spending Account in or on account of any taxable year of the Participant will not exceed the lesser of the earned income limitations described in section 129(b) of the Code or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of section 21(e) of the Code). Expenses for which the Participant claims the Dependent Care Tax Credit under Code section 21 cannot be reimbursed. The Daily Administrator or the Component Program Document may also specify a minimum and maximum amount that may be allocated to the Dependent Day Care Spending Account by a Participant in or on account of any Plan Year. Any such minimum or maximum will be set forth in the Annual Enrollment materials, which are hereby incorporated by reference.

7.3 Nondiscrimination Requirements

It is the intent of this Dependent Day Care Spending Account not to discriminate in favor of highly compensated employees or key employees or their dependents within the meaning of section 129 of the Code. If the Daily Administrator deems it necessary to avoid discrimination under this Dependent Day Care Spending Account, it may, but will not be required to, reject any elections or reduce contributions or benefits in order to assure compliance with this Section 7.3. Any act taken by the Daily Administrator under this Section 7.3 will be carried out in a uniform and nondiscriminatory manner.

7.4 Coordination With Cafeteria Component Program

Those Employees specified in the Dependent Day Care Spending Account Component Program Document will be eligible to elect to participate in the Cafeteria Component Program and receive benefits under this Dependent Day Care Spending Account. The enrollment under the Cafeteria Component Program will constitute enrollment under this Dependent Day Care Spending Account. In addition, other matters concerning contributions, elections and the like will be governed by the general provisions of the Plan and the Dependent Care Spending Account Component Program Documents.
7.5 Dependent Day Care Spending Account Claims

(a) **Reimbursement of Employment-Related Dependent Day Care Expenses.** All eligible Employment-Related Dependent Day Care Expenses incurred by a Participant during the Plan Year will be reimbursed from his Dependent Day Care Spending Account, even if the incurrence or submission of such a claim occurs after his participation under the Dependent Day Care Spending Account ceases, if the Participant timely files for reimbursement as described in (c) below. In general, a claim is incurred when the care is provided. A Participant’s Compensation reductions and election to participate in the Dependent Day Care Spending Account will automatically terminate as of the day of the Participant’s termination of employment.

(b) **Maintain Account Balance Available.** The Daily Administrator will direct the reimbursement to each eligible Participant for all eligible Employment-Related Dependent Day Care Expenses, up to the balance in the Participant's Dependent Day Care Spending Account at the time the expenses are submitted for reimbursement.

(c) **Claim Filing Deadline/Forfeitures.** Claims for the reimbursement of Employment-Related Dependent Day Care Expenses incurred in any Plan Year must be filed by March 31 of the Plan Year following the Plan Year in which the expenses were incurred unless specified otherwise in the Component Program Documents. Employment-Related Dependent Day Care Expenses properly submitted for payment will be paid as soon as administratively possible after the claim has been filed.

The Daily Administrator, in its sole discretion, will determine how forfeitures are allocated, from among the following options: (a) retained by the Employer, (b) used to defray expenses of administering the Cafeteria Component Program; (c) used to reduce Compensation reduction amounts for the immediately following Plan Year, or (d) returned to Employees on a reasonable and uniform basis (but not based on individual claims experience). If not retained by the Employer or used to defray expenses of administering the Cafeteria Component Program, the forfeitures will be allocated among Employees on a reasonable and uniform basis.

(d) **Manner of Payment.** Reimbursement payments under this Dependent Day Care Spending Account will be made directly to the Participant. However, in the Daily Administrator's discretion, payments may be made directly to the service provider. Expenses cannot be reimbursed from the Dependent Day Care Spending Account until they have been incurred. Expenses are incurred when the care is provided and not when the Participant is formally billed for, charged for or pays for the care.

(e) **Substantiation of Claims.** All claims must be substantiated in accordance with this section or the terms of the Component Program Documents prior to payment or reimbursement of any Employment-Related Dependent Day Care Expenses. In general, all claims must be substantiated by information from a third-party that
is independent of the Employee and his Dependents. In addition, all claims must set forth:

- the person(s) on whose behalf the Employment-Related Dependent Day Care Expense was incurred;
- the nature and date of the expenses so incurred;
- the amount of the requested reimbursement;
- the name of the person, organization or entity to whom the expense was or is to be paid and taxpayer identification number (Social Security number, if a person);
- the relationship, if any, of the person performing the services for the Participant (if the services were performed by a child of the Participant, the age of the child);
- a statement that such expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;
- the Participant’s certification that he has no reason to believe that the reimbursement requested, added to his other reimbursements to date for expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant;
- a statement as to where the services were performed;
- if any of the services were performed outside the home, a statement as to whether the Qualifying Individual for whom the services were performed spends at least 8 hours a day in the Participant's household;
- if the services were being performed in a day care center, a statement:
  - That the day care center complies with all applicable laws and regulations of the state of residence; and
  - That the day care center provides care for more than 6 individuals (other than individuals residing at the center).
- if the Participant is married, a statement containing the following:
  - The Spouse's salary or wages if he or she is employed; or
  - If the Participant’s Spouse is not employed, that
    - he or she is incapacitated; or
    - he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution
• other such details about the expenses that may be requested by the Daily Administrator on the reimbursement request form or otherwise.

The application will be accompanied by those documents listed above from an independent third party, along with any other documentation that the Daily Administrator may request. There can be no self-substantiation of an expense by a Participant (i.e., cancelled checks to a babysitter are not sufficient, standing alone).

7.6 Statement of Benefits

The Daily Administrator will periodically (but no later than January 31st of each year) furnish to each Employee who is a Participant in the Dependent Day Care Spending Account a statement of the contributions made to such Account and the benefits paid from such Account on or on behalf of such Participant during the Plan Year.

End of Article VII
ARTICLE VIII — HEALTH SAVINGS ACCOUNTS

8.1 Establishment of Health Savings Account

A Health Savings Account or HSA may be established by an HSA Eligible Participant, in his sole discretion, with an Approved HSA Vendor. The terms of participation in the HSA (including, but not limited to, investments, account administration, and accepted rollovers) will be determined by such Approved HSA Vendor except, to the extent that such terms are not set forth by such Approved HSA Vendor or such terms do not comply with section 223 of the Code or other Internal Revenue Service guidance addressing health savings accounts, the terms of participation in the HSA will be governed by Code section 223 and such other Internal Revenue Service guidance.

8.2 Contributions to Health Savings Account

(a) **Employee Contributions.** An HSA Eligible Participant who has established an HSA with an Approved HSA Vendor may make contributions to such HSA on a pre-tax basis through the Cafeteria Program as set forth in Article IV. Such contributions will be subject to any limitations set forth by the Approved HSA Vendor except, to the extent that such Approved HSA Vendor has failed to set forth any limitations on contributions or such limitations conflict with section 223 of the Code or other Internal Revenue Service guidance addressing health savings accounts, the terms of Code section 223 or such other Internal Revenue Service guidance will govern.

(b) **Employer Contributions.** The Employer may, but is not required to, make contributions through the Cafeteria Program to an HSA established with an Approved HSA Vendor by an HSA Eligible Participant. Employer HSA contributions, if any, will only be deposited in an HSA maintained by an Approved HSA Vendor. Such contributions will be subject to the nondiscrimination requirements of section 125 of the Code and any applicable limits on Employer Contributions set forth in section 223 of the Code or other Internal Revenue Service guidance.

8.3 Distributions from Health Savings Account

(a) **Transfer or Rollover of HSA Balance to Non-Approved HSA Vendor.** An HSA Eligible Participant may, at any time, transfer or rollover his or her HSA account balance to a vendor that is not an Approved HSA Vendor. However, any Employee contributions made by or on behalf of an HSA Eligible Participant to a health savings account maintained by a vendor that is not an Approved HSA Vendor must be made on an after-tax basis by the HSA Eligible Participant, and may not be made pre-tax through the Cafeteria Program or through the Employer's payroll system. Further, Employer HSA contributions, if any, will only be deposited in an HSA established with and maintained by an Approved HSA Vendor.

(b) **Other Distributions or Rollovers. (Including Rollovers to Approved HSA Vendors).** Distributions and rollovers (other than a rollover described in Paragraph (a) above) from an HSA established by an HSA Eligible Participant will be governed by section 223 of the Code, applicable Internal Revenue Service guidance.
guidance, and the Approved HSA Vendor (to the extent that any limitations or requirements established by the Approved HSA Vendor do not conflict with section 223 of the Code or other applicable Internal Revenue Service guidance). Taxation of such distributions and/or rollovers will be determined under Code section 223 and other applicable Internal Revenue Service guidance. Each HSA Eligible Participant has sole control and is exclusively responsible for expending HSA funds.

8.4 Responsibilities of HSA Eligible Participant

A health savings account is an individual account established by an HSA Eligible Participant with a vendor. Although HSA contributions made by or on behalf of an HSA Eligible Participant who has established an HSA with an Approved HSA Vendor may be made on a pre-tax basis through the Cafeteria Program, an HSA is not intended to be an “employee welfare benefit plan” within the meaning of ERISA, and is not a benefit program established or maintained by the Employer. Other than contributions made by the Employer or forwarded through its payroll department, the Employer will not monitor HSA contributions (including determinations as to whether such contributions exceed the statutory limits), investments of HSA account balances, or distributions or rollovers from the HSA. Such determinations and monitoring are the responsibility of the HSA Eligible Participant.

End of Article VIII
ARTICLE IX—HEALTH REIMBURSEMENT ACCOUNT PROGRAM

9.1 Establishment of Plan

This Article IX constitutes a separate plan document that sets forth the terms of the Health Reimbursement Account Program. This Article IX is intended to qualify as a health reimbursement arrangement and a “health plan” under sections 105 and 106 of the Code and will be interpreted in a manner consistent with such Code sections and the Treasury regulations thereunder. Eligible Employees who participate in this Health Reimbursement Account Program may submit claims for the reimbursement of certain Medical Expenses. The only benefit provided under this Article IX will be reimbursement of allowable Medical Benefits; no cash or other benefits may be received under this Article IX.

9.2 Definitions

For purposes of this Article IX and the Plan, the terms below have the following meanings:

(a) “Medical Expense” means any expense for medical care within the meaning of section 213 of the Code and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. However, a Participant may not be reimbursed for (i) the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant’s Spouse or individual policies maintained by the Participant or his Spouse or Dependent, (ii) an over-the-counter medicine or drug (except for insulin) unless a prescription (as such term is defined in Internal Revenue Service Notice 2010-59 or subsequent guidance) has been obtained for the over-the-counter medicine or drug, or (iii) “qualified long-term care services” as defined in section 7702B(c) of the Code. A Participant also may not be reimbursed for Medical Expenses incurred by a Domestic Partner of the Participant or a Child of the Domestic Partner if such individual is not the Participant’s federal tax dependent within the meaning of section 152 of the Code (determined without regard to sections 152(b)(1), (b)(2), and (d)(1)(B) of the Code). Further, the Health Reimbursement Account Program will only allow reimbursements for certain Medical Expenses as described in the Component Program Documents for the Health Reimbursement Account Program.

(b) “Health Reimbursement Account” means one of the funds established for Participants under this Article IX to which Employer contributions made on the Participants’ behalf are allocated and from which allowable Medical Expenses may be reimbursed.

(c) “Health Reimbursement Account Program” means the plan of benefits contained in this Article IX, which provides for the reimbursement of eligible Medical Expenses incurred by a Participant or his Dependents, except that Medical Expenses incurred by a Domestic Partner or a Child of a Domestic Partner who is not the Participant’s federal tax dependent within the meaning of section 152 of the Code (determined without regard to sections 152(b)(1), (b)(2), and (d)(1)(B) of the Code), will not be eligible for reimbursement under this Health Reimbursement Account Program.
The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Incentive Account Arrangement.

9.3 Health Reimbursement Accounts

The Daily Administrator previously established a Health Reimbursement Account for each Employee who participates in the Health Reimbursement Account Program. Unless the Company chooses to establish a trust or other funding vehicle to fund the Health Reimbursement Account Program, no separate fund or account will be maintained for any Health Reimbursement Account, and the benefits provided under the Health Reimbursement Account Program will be funded solely by the general assets of the Employers. A Participant will forfeit the balance, if any, of his Health Reimbursement Account if he is an HSA Eligible Participant for a Plan Year (e.g., enrolls in the high deductible medical plan option under the Medical Program). Such balance once forfeited is not subject to restoration.

9.4 Employer Contributions

The Employer will bear the entire expense associated with funding Participants' Health Reimbursement Accounts and will, in its sole and absolute discretion, determine the amount, if any, that will be contributed to each Participant's Health Reimbursement Account, each Plan Year. A Participant may not make contributions to the Health Reimbursement Account Program through the Cafeteria Plan. The Employer and/or Employee will bear the expense associated with continuation coverage under COBRA as described in the applicable Component Program Documents.

9.5 Amount Allocated to the Health Reimbursement Account Program

A Participant's Health Reimbursement Account will be increased each Plan Year by the amount, if any, the Employer has elected to contribute to the Health Reimbursement Account Program for such Participant. A Participant's Health Reimbursement Account will be reduced by the amount of any allowable Medical Expense reimbursements paid or incurred on behalf of a Participant pursuant to this Article IX. The sum of the contributions which have been allocated to the Participant's Health Reimbursement Account for a Plan Year plus any amount carried forward from a prior Plan Year minus the reimbursements paid or incurred during the Plan Year at any given point in time will be the amount available to the Participant for the reimbursement of allowable Medical Expenses.

9.6 Coordination of Payment

Under certain circumstances, coverage for an allowable Medical Expense may be provided under more than one of the following accounts: (i) a Participant's Health Reimbursement Account and (ii) a Participant's Healthcare Spending Account. When coverage is provided under more than one such account, reimbursement of the Medical Expense will be made from such accounts in the order specified by the Participant.

In no event, will the total amount reimbursed from such accounts exceed the allowable amount of the Medical Expense.
9.7 Carryover of Unused Balance

Except as provided in the Component Program Documents for the Health Reimbursement Account Program, each Participant is entitled to carryover all or the allowable portion of any unused balance in his Health Reimbursement Account at the end of the Plan Year to the subsequent Plan Year for use in that year, or any future periods in which the Participant remains eligible under the Health Reimbursement Account Program to participate in the Health Reimbursement Account.

9.8 Forfeitures

With the exception of during continuation coverage under COBRA, any monies remaining in a Participant's Health Reimbursement Account when the Participant ceases to be eligible to participate in the Health Reimbursement Account Program (and after processing all claims incurred while the Participant was eligible to participate) will be forfeited. In such event, the Participant will have no further claim to such amount for any reason.

9.9 Nondiscrimination Requirements

It is the intent of this Health Reimbursement Account Program not to discriminate in favor of "highly compensated individuals" or "highly compensated participants" as defined in section 105 of the Code in violation of the Code and the rulings and Treasury regulations thereunder.

9.10 Coordination with Plan Document

Matters concerning contributions, elections, claims for benefits, and the like will be governed by the general provisions of the Plan and the terms of Component Program Documents for this Health Reimbursement Account Program.

9.11 Health Reimbursement Account Claims

(a) **Reimbursement of Medical Claims.** Medical Expenses incurred by a Participant that are eligible to be reimbursed under this Article XVII will be reimbursed even though the submission of such a claim occurs after his participation hereunder ceases; provided that the Medical Expenses were incurred during the period while he was a Participant in the Health Reimbursement Account Program. Such reimbursement will not exceed the balance of the Participant's Account at the time such allowable Medical Expenses are incurred. Substantiation of such Medical Expenses must be provided in a form acceptable to the Daily Administrator. Furthermore, notwithstanding anything herein to the contrary, reimbursement will not be made from the Health Reimbursement Account Program for any amounts that are paid or reimbursed under any health care plan covering the Participant and/or his Spouse or Dependents.

(b) **Claim Filing Deadline.** Allowable claims for the reimbursement of Medical Expenses will be paid as soon after a claim has been filed with the Administrative Provider as is administratively practicable; provided that claims must be submitted in the time period provided in the Component Program Documents for
the Health Reimbursement Account Program in order to be eligible for reimbursement. Any dispute concerning a claim for the reimbursement of Medical Expenses under the Health Reimbursement Account Program will be subject to the claims provisions of Article XI unless otherwise provided in the Component Program Documents.

(c) Manner of Payment. Reimbursement payments under the Health Reimbursement Account Program will be made directly to the Participant. However, in the Daily Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement will be made to the Administrative Provider on an acceptable form within a reasonable time of incurring the debt or paying the service. The application will include a written statement from an independent third party stating that the Medical Expense has been incurred, the date of the Medical Expense, and the amount of such expense, and any other information about the Medical Expenses that may be requested by the Administrative Provider on the reimbursement request form or otherwise. Furthermore, if required by the Administrative Provider, the Participant will provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Reimbursement Account Program, such amount will not be claimed as a tax deduction. The Administrative Provider will retain a file of such applications.

9.12 Participant Account Statements

The Administrative Provider will, on a periodic basis, provide each Participant with a statement which includes the balance of his Health Reimbursement Account as well as provide a copy of such information to any Participant who makes a specific written request.

End of Article IX
ARTICLE X — SUBROGATION

10.1 Plan’s Right of Subrogation

Subject to the provisions of this Article X (and except as provided otherwise under a superseding provision of a Component Program applicable pursuant to section 10.7 below), if a Participant or Covered Dependent is entitled to a benefit under the Plan for a Condition caused or possibly caused by a Third Party or for which a Third Party may be liable, as a condition to receiving this benefit the Committee or Daily Administrator may require the Participant or Covered Dependent to sign an agreement to reimburse the Plan in full and give the Plan first priority from the amounts recovered from such Third Party (as set forth in section 10.2 below), and the Plan will be subrogated to all rights, however arising, of the Participant or Covered Dependent against the Third Party.

The right of subrogation set forth herein will not limit any additional rights of subrogation the Plan may have under the applicable laws of any State to seek repayment of the benefit from the Third Party.

10.2 Amounts Recoverable

The Plan is subrogated to any right of a Participant or Covered Dependent to recover any and all benefits, which have been paid or are payable—or which are likely (in the opinion of the Committee or Daily Administrator) to become payable under the Plan—and which are related to any Condition for which a Third Party is or may be liable, without regard to whether the payment is characterized as recovery for pain and suffering, mental anguish, punitive damages, or any other basis of recovery other than for medical or other welfare benefits provided by the Plan and regardless of whether the liability of the Third Party is reduced to a recovery as a result of legal proceedings, arbitration, compromise settlement or otherwise.

The Plan’s subrogation rights under this Article X will be a first priority claim against all Third Parties and the amount to which the Plan is entitled pursuant to its rights under this Article X will be paid to the Plan before any amounts are paid to the Participant or Covered Dependent, or in the event such amount to which the Plan is entitled is not paid immediately to the Plan, such amount will be segregated and held in constructive trust for the Plan. In addition, the Plan may recover from the amounts recovered from such Third Parties its reasonable costs and attorneys’ fees.

The amount to which the Plan is subrogated, or the amount to which the Plan is entitled to reimbursement, will not be limited or reduced because the Third Party is liable only in part, the Third Party’s resources or insurance is limited, the Participant has not been fully compensated (i.e., made whole), or to share in a pro rata allocation of a Participant’s fees and costs (including attorney fees) incurred in pursuit of a claim (e.g., “common fund doctrine”), or because of any other reason.

To the extent the amount to which the Plan is subrogated, or the amount to which the Plan is entitled to reimbursement, is limited or reduced under the applicable laws of any state, the Plan will have the right to reimbursement from a Participant for the amount by which the Plan’s rights are limited or reduced by state law.
10.3 **Limitation on Plan's Recovery**

The Plan's right of subrogation will not exceed either (a) the sum of the amount of benefits paid, payable, or likely (in the opinion of the Committee or Daily Administrator) to become payable under the Plan, plus the Plan's reasonable costs and attorneys' fees, or (b) the total amount of the recovery from Third Parties.

10.4 **Enforcement**

To enforce any provision of this Article X, the Committee or Daily Administrator may:

(a) Bring an action in the name of the Plan, Participant or Covered Dependent against a Third Party or the Third Party's liability carrier or in the case of uninsured or underinsured motorist coverage, the Participant's or Covered Dependent's automobile insurance carrier;

(b) Join in any action by a Participant or Covered Dependent against a Third Party or the Third Party's liability carrier or in the case of uninsured or underinsured motorist coverage, the Participant's or Covered Dependent's automobile insurance carrier;

(c) Offset future benefits by amounts which a Participant or Covered Dependent has obtained (or could have obtained with reasonable diligence) from a Third Party or the Third Party's liability carrier or in the case of uninsured or underinsured motorist coverage, the Participant's or Covered Dependent's automobile insurance carrier;

(d) Bring an action to set aside any settlement agreement entered into without the consent of the Committee or Daily Administrator;

(e) Bring an action against a Participant or Covered Dependent for an equitable lien or constructive trust against amounts recovered by a Third Party;

(f) Without consent of or notice to any Participant or Covered Dependent, to the extent permitted by law, release to or obtain from any other individual or entity any information which the Committee or Daily Administrator deems necessary or advisable for the enforcement of the Plan's subrogation rights under this Article X; or

(g) Take any other action it deems appropriate.

10.5 **Obligations of Participants**

In addition to the other obligations set forth in this Article X, the following obligations apply to Participants and Covered Dependents:

(a) The Participant or Covered Dependent will cooperate with the Committee's efforts to enforce the Plan's rights under this Article X, execute and deliver to the Committee or Daily Administrator, as applicable, any reimbursement agreement, assignment, and other documents the Committee or Daily Administrator requests for enforcing the Plan's rights under this Article X, will provide to the Committee
or Daily Administrator any information regarding recovery sought or received from any third party (including the amount and source of such recovery), will not take any action which might prejudice the Plan's rights under this Article X, and will not release any Third Party (even if the release purports to be a partial release or a release for the excess liability over Plan benefits) without the Committee's or Daily Administrator's advance written consent. The Plan's rights will not be affected by a release of any Third Party entered into without such consent.

(b) If a Participant or Covered Dependent initiates a liability claim against any Third Party or the Third Party's liability carrier, or if recovery is sought against the Participant's or Covered Dependent's automobile insurance carrier under the uninsured or underinsured endorsement, the amounts described in Section 10.2 must be included in the claim.

(c) If a Participant or Covered Dependent receives money from or on behalf of any Third Party, the Participant or Covered Dependent will hold such money in trust for the Plan, to the extent of the Plan's rights under this Article X. Failure to do so will constitute a breach of the Participant's or Covered Dependent's fiduciary duty under the Plan.

(d) Each Participant or Covered Dependent who incurs any Condition will inform the Committee or Daily Administrator whenever it appears a Third Party is or may be liable to the Participant or Covered Dependent as a result of that Condition. Each Participant or Covered Dependent will inform any Third Party, attorney, and insurance carrier, as well as any other individual or entity connected with a Condition or involved in the collection of any amount connected with a Condition, of the Plan's right of subrogation.

(e) Failure of the Participant or Covered Dependent to comply in all respects with this Article X may, in the Committee's or Daily Administrator's discretion, cause a denial of benefits for a Condition or a termination of coverage for the Participant or Covered Dependent under the applicable Component Program.

10.6 Waiver

The Committee or Daily Administrator may waive or modify any of the provisions of this Article X whenever it deems appropriate under the facts and circumstances of a particular case.

10.7 Coordination with Component Program Document

If a Component Program Document contains subrogation provisions, those provisions will control over this Article X with respect to that Component Program to the extent those provisions are in compliance with the law, including any applicable case law, and are drafted to provide for maximum allowable recovery by the Component Program.
However, if the provisions in the Component Program Document do not address or are ambiguous with respect to a particular issue, and this Article X would address that issue or ambiguity, then this Article X will apply and will control to the extent necessary to resolve the issue or ambiguity.

End of Article X
ARTICLE XI -- CLAIMS PROCEDURE

11.1 Claims For Benefits

Claims for benefits or reimbursements under the Health Care Components and Disability Component Programs will be determined in accordance with the claims procedures set forth in the Component Program Documents. Each Health Care Component subject to Health Care Reform as a non-grandfathered plan, as such term is defined in Health Care Reform, will comply with the claims rules applicable to non-grandfather plans under Health Care Reform and such claims rules will be described in the Component Program Documents.

Claims for benefits or reimbursement (other than for health care or disability claims) under the Plan will be submitted and processed in accordance with this Article XI, unless the Component Program Document contains its own claims procedures, in which case the Component Program Document's claims procedures will apply with respect to that Benefit Program. However, if a non-health or non-disability Component Program Document's claims procedures do not address or are ambiguous with respect to a particular issue, and this Article XI would address that issue or ambiguity, then this Article XI will apply and will control to the extent necessary to resolve the issue or ambiguity. Further, to the extent that a non-health or non-disability claims procedure does not provide for binding arbitration, the provisions of Section 11.2 will apply.

(a) Initial Claim. An initial claim for benefits under this Plan or the Component Programs must be filed by a claimant or his duly authorized representative with the Administrative Provider or Daily Administrator, as applicable. If the claim is denied, the Administrative Provider or Daily Administrator, as applicable, will provide notice to the claimant, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim and notice of the need for an extension is given to the claimant within the initial 90-day period. Any such extension may not exceed 90 days from the date notice of the claim would otherwise be given. If notice of the denial of the claim, or need for an extension, is not provided within the 90-day period specified above, then the claim will be deemed denied. The period of time within which a denial must be made, as described in this Paragraph (a), will begin at the time a claim is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

The notice of a denial of a claim will be written in a manner calculated to be understood by the claimant and will set forth:

(i) the specific reason or reasons for the denial of the claim;

(ii) specific references to the pertinent Plan or Component Program Document provisions on which the denial is based;

(iii) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and
(iv) an explanation of the Plan's claim procedure and of the Participant's right to binding arbitration as described in Section 11.2 or to bring a claim pursuant to section 502(a) of ERISA in the event of a final adverse benefit determination.

(b) **First Level Review.** The claimant may appeal the denial of his claim for benefits to the Administrative Provider or Daily Administrator, as applicable, within 60 days after receipt of the notice of the denial of the claim or 60 days from the date such claim is deemed to be denied. In connection with the request for first level review, the claimant or his duly authorized representative may review pertinent documents and submit issues and comments in writing. The claimant or his duly authorized representative (1) may contact the Daily Administrator to establish a mutually agreeable time during normal business hours of the Employer to review any pertinent documents and (2) will be provided upon request and free of charge, copies of all documents, records, and other materials relevant to the claim for benefits, without regard to whether such documents, records, and other materials were relied upon in making the claim denial.

(c) **Decision on First Level Review.** The Administrative Provider or Daily Administrator, as applicable, will issue a decision in writing or electronically on first level review not later than 30 days after receipt of a request for review, unless special circumstances require an extension of time for processing, in which event a decision will be rendered as soon as possible, but in no event later than 60 days after such receipt. The decision of the Administrative Provider or Daily Administrator will be written in a manner calculated to be understood by the claimant and will include specific reasons for the decision and specific references to the pertinent Plan or Component Program Document provisions on which the decision is based. If the claim is denied on first level review, the decision will also include an explanation of the Plan's claim procedure and of the Participant's right to elect binding arbitration as described in Section 11.2 or to bring a claim pursuant to section 502(a) of ERISA in the event of a final adverse benefit determination. If the decision on first level review is not furnished within the time specified above, the claim will be deemed to be denied on first level review.

(d) **Second Level Review.** The Company has appointed the Committee as the final arbiter of benefit appeals. Accordingly, the claimant may appeal a denial of his claim for benefits on first level review to the Committee within 60 days after receipt of the notice of the denial of the claim on first level review or 60 days from the date such claim is deemed to be denied on first level review. In connection with the request for second level review, the claimant or his duly authorized representative may review pertinent documents and submit issues and comments in writing. The claimant or his duly authorized representative (1) may contact the Daily Administrator to establish a mutually agreeable time during normal business hours of the Employer to review any pertinent documents and (2) will be provided upon request and free of charge, copies of all documents, records, and other materials relevant to the claim for benefits.

(e) **Decision on Second Level Review.** The Committee will issue a decision on second level review not later than 30 days after receipt of a request for review, unless special circumstances require an extension of time for processing, in
which event a decision will be rendered as soon as possible, but in no event later than 60 days after such receipt. The decision of the Committee will be written in a manner calculated to be understood by the claimant and will include specific reasons for the decision and specific references to the pertinent Plan or Component Program Document provisions on which the decision is based. If the claim is denied on second level review, the decision will also advise the claimant of his right to elect binding arbitration or to bring an action under section 502(a) of ERISA. If the decision on second level review is not furnished within the time specified above, the claim will be deemed to be denied on second level review.

(f) Exhaustion Required. Completion of the claims procedures described in this Section 11.1 will be a condition precedent to commencing binding arbitration or any legal or equitable action regarding a claim for benefits under the Plan by a claimant, or by any other person or entity claiming rights through such claimant. However, the Committee may waive in writing this completion requirement.

11.2 Binding Arbitration

If the claim is still not resolved to the claimant's satisfaction after review by the Committee, the claimant may elect between submitting the matter to binding arbitration or filing a case in state or federal district court. A claimant may choose to submit his claim to binding arbitration, but will not be forced to do so. A decision as to whether to submit a claim to binding arbitration will not affect the claimant's rights to any other benefits under the Plan or a Component Program. However, once the claimant elects binding arbitration, the decision is final and the claimant will not have the right to bring a lawsuit in court.

(a) Timing. A claimant may request binding arbitration in writing to the Committee within one year of his last appeal. This means that the claimant may contest the denial of his claim through arbitration only by submitting the matter to arbitration within this deadline. In this event, the claimant and the Committee will select an arbitrator from a list of names supplied by the American Arbitration Association ("AAA"), in accordance with the AAA's selection procedures, and the arbitration will be conducted in accordance with the AAA's commercial arbitration rules and procedures.

(b) Venue. The arbitration will be held in a major metropolitan area (closest to the claimant's place of employment), unless the claimant and the Committee agree to another site. The arbitrator's authority will be limited to the affirmation or reversal of the Committee's denial of the claim, based on whether the claim was denied arbitrarily or capriciously. The arbitrator does not have the power to alter, add to, or subtract from any provision of the Plan) and cannot interfere with the proper exercise of the Committee's discretion. In addition, the arbitrator does not have the authority to award extra-contractual, compensatory or consequential damages.

(c) Final and Binding. Except as otherwise required by applicable law, the arbitrator's decision will be final and binding between the claimant and the Plan, if warranted by the evidence and if reasonable based on applicable law and provisions of the Plan and may be filed with any court of competent jurisdiction.
Arbitration decisions will not serve as precedent for any other claim unless the decision has been confirmed by a court of competent jurisdiction.

(d) **Procedural Protections.** The Plan will waive any right it may have to assert that the claimant failed to exhaust his administrative remedies if the claimant does not elect to submit a benefits dispute to binding arbitration; provided that the benefits dispute has been processed through the appeal process set forth in Section 11.1 (to the extent applicable).

Any statute of limitations or other timeliness defense the Plan may raise will be tolled during the time binding arbitration is pending.

Binding arbitration is available only after the final appeal stage of the claims procedures described in Section 11.1 (to the extent applicable).

(e) **Information.** Upon written request, the claimant will be provided sufficient information to make an informed judgment about whether to submit his claim to binding arbitration.

The claimant will not be required to pay any fees or costs associated with the binding arbitration offered under the Plan. However, if the claimant chooses to be represented by an attorney during the binding arbitration process, he will be responsible for his attorney’s fees. The arbitrator, as part of his award, may provide for the payment of such attorney’s fees.

11.3 **Payment of Benefits**

(a) **Time and Form of Payment.** If the Administrative Provider, Daily Administrator or Committee determines that a claimant is entitled to a benefit hereunder, payment of such benefit will be made to such claimant (or commence, as applicable) as soon as administratively practicable after the date the Administrative Provider, Daily Administrator, or Committee determines that such claimant is entitled to such benefit or on such other date as may be established pursuant to the terms of the applicable Component Program and, in the absence of such terms in accordance with the following:

(i) Any benefit assigned to a provider of services or to a former Spouse will be paid directly to such provider or former Spouse, or to the Participant, whichever the Administrative Provider, Daily Administrator or Committee chooses;

(ii) Any benefit payable upon the death of a Participant, Spouse or Dependent will be paid to the estate of such person or to the designated beneficiary, whichever the Administrative Provider, Daily Administrator or Committee chooses;

(iii) Any benefit payable with respect to a child covered by a qualified medical child support order (within the meaning of section 609 of ERISA)—other than a benefit described in Subparagraph (i) or (ii) above—will be paid to the custodial parent of such child, if the Administrative Provider, Daily Administrator or Committee so chooses; and
(iv) Any other benefit payable will be paid to the Participant or Dependent (or in the case of a Dependent child, the Participant).

11.4 Authorized Representatives

An authorized representative may act on behalf of a claimant in pursuing a benefit claim or an appeal of a denial of a benefit claim. An individual or entity will only be determined to be a claimant's authorized representative for such purposes if the claimant has provided the Committee with a written statement identifying such individual or entity as his authorized representative and describing the scope of the authority of such authorized representative.

If a claimant identifies an individual or entity as his authorized representative in writing to the Committee but fails to describe the scope of the authority of such authorized representative, the Committee will assume that such authorized representative has full powers to act with respect to all matters pertaining to the claimant's benefit claim under the Plan or appeal of a denial with respect to such benefit claim.

11.5 Compromise of Claims

A claim for benefits may be compromised on any terms acceptable to both the Participant and the Committee.

11.6 Limitations Period on Actions Against the Plan

A Claimant must bring any legal or equitable action to contest a final decision made with respect to a claim under this Article XI within 2 years of the date that the Committee (or the individual or entity who is responsible for issuing such final claims determination) sends written or electronic notification of such final claims determination to the Claimant, or the Claimant's right to bring such a legal or equitable action will be waived.

End of Article XI
ARTICLE XII — FUNDING OF PLAN

12.1 Source of Benefits

In general, all contributions and benefits under the Plan are paid from the general assets of the Company. However, the Committee or Daily Administrator may decide to provide some or all of the benefits under a benefit program through insurance and may, or may cause the Plan to purchase one or more insurance contracts or policies for such purpose.

To the extent the benefits provided under the Plan are payable from the general assets of the Company, nothing in this Plan will require the Company, the Committee or the Daily Administrator to maintain any fund or segregate any amount for the benefit of any Participant (except to the extent required by law), and no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the Company from which any payment under the Plan may be made.

Plan benefits and expenses will first be paid out of assets attributable to Participant contributions and compensation reduction agreements; however, the Daily Administrator will not be required to separately account for such amounts.

12.2 HMO and PPO Insurance Premiums

HMO and PPO premiums will be paid to the applicable HMO or PPO from the Employer within the time required by the applicable Component Program or applicable HMO or PPO contract. All premiums will be paid within the time prescribed by Department of Labor regulation section 2510.3-102.

12.3 Participant Contributions

(a) **Amount.** Participants' contributions will be determined by the Employer and will be communicated to the Employee at enrollment. Upon enrollment of a Participant in, amendment of coverage under, or enrollment of a Dependent in any Component Program, the Participant will be advised of any required contributions under that Component Program. Further, Participants' contributions may be changed by and in the sole discretion of the Employer (subject to the rules regarding changes in Participant contributions under the Cafeteria Component Programs), and each Participant will be advised of any change in the amount of contributions as provided in the applicable Component Program or, in the absence of such provision, in writing no later than 31 days prior to the effective date of the change. A COBRA Beneficiary will be required to contribute any additional amount determined in accordance with Section 5.6.

(b) **Payment.** Participants will pay their contributions in the manner and within the time period set forth by the applicable Component Program.

(c) **Certain Amounts Pre-Tax.** Subject to the terms and conditions set forth in Article IV regarding the Cafeteria Component Programs, Participants will be permitted to elect to pay for coverage under certain Component Programs on a pre-tax basis. If a Participant makes such an election, the Participant's Compensation will be reduced, and an amount equal to the reduction will be
contributed by the Employer and applied to the Participant's share of any cost of coverage under the applicable Component Program.

End of Article XII
ARTICLE XIII — ADMINISTRATION OF PLAN

13.1 Plan Administrator

The Committee will be the Plan Administrator. The general administration of the Plan will be vested in the Plan Administrator. Except as otherwise provided in an insurance policy, HMO contract, or summary plan description, for purposes of ERISA, the Committee will be the “Plan Administrator” and the named “fiduciary” with respect to the Component Programs. The duties and responsibilities of the Committee will be outlined in a Charter to be adopted by the Committee.

13.2 Membership of the Committee

The Committee will have no less than three members. The Company’s Senior Vice President of Human Resources will appoint a chairman of the Committee, who will hold office until resignation, death or removal by the Senior Vice President of Human Resources. All other Committee members may be appointed by the Committee Chairman or by the Company’s Senior Vice President of Human Resources and will hold office until resignation, death or removal by the Senior Vice President of Human Resources or by the Chairman. The Secretary of the Committee, who may or may not be a member of the Committee, will cause to be maintained in the office of the Committee, for the purpose of inspection, an accurate schedule listing the names of all persons from time to time serving as the named fiduciaries of the Plan.

13.3 Appointment Authority of Committee

The Committee may appoint a Daily Administrator to carry out its duties under the Plan. If so appointed the Daily Administrator will exercise all of the duties of the Committee specified in Section 13.5. The Committee may also appoint an investment manager appointed pursuant to Section 13.19 exclusive fiduciary authority and discretion to manage and control all or any portion of the assets of the Plan. In addition, the Committee, or Daily Administrator if one is appointed by the Committee, may delegate all or a portion of its administrative and/or fiduciary duties to an individual or entity as provided in Section 13.5.

13.4 Discretion to Interpret Plan

The Committee and Daily Administrator will have full and absolute discretion to construe and interpret all provisions of the Plan and the Component Programs, including the discretion to resolve ambiguities, inconsistencies, or omissions conclusively; provided, however, that all such discretionary interpretations and decisions will be applied in a uniform and nondiscriminatory manner to all Covered Persons who are similarly situated. All decisions of the Committee or Daily Administrator upon all matters within the scope of its authority will be binding and conclusive upon all persons.

13.5 Powers and Duties

In addition to the powers described in Section 13.1 and all other powers specifically granted under the Plan, the Committee will have all powers necessary or proper to administer the Plan and to discharge its duties under the Plan, and it will have full and
absolute discretion in its exercise thereof. The Committee has appointed the Daily Administrator to carry out the following powers and duties:

(a) To make and enforce any rules, regulations, and procedures it deems necessary or proper for the orderly and efficient administration of the Plan;

(b) To select and appoint an Administrative Provider as set forth in Section 13.17;

(c) To purchase insurance contracts to insure the benefits under the Component Programs and enter into Administrative Agreements with Administrative Providers;

(d) To direct and monitor the activities of the Administrative Providers;

(e) To delegate its duties and responsibilities to any individual or entity;

(f) Unless such authority is delegated to an Administrative Provider pursuant to Section 13.17, to interpret and decide all matters of fact in granting or denying claims for benefits under the Plan, (except for the decision on an appeal of a denial of benefits which pursuant to Article XI is vested in the Committee or an Independent Fiduciary), its interpretation and decision thereof to be final and conclusive on all persons claiming benefits under the Plan;

(g) To determine eligibility under the terms of the Plan, its determination thereof to be final and conclusive on all persons;

(h) Unless such authority is delegated to an Administrative Provider pursuant to Section 13.17, to determine the amount of and authorize the payment of benefits under the Plan, its determination and authorization thereof to be final and conclusive on all persons;

(i) To prepare, distribute and/or file all applicable notices, reports, statements, and summary plan descriptions and other information explaining the Plan;

(j) To obtain from the Employer, Employees, beneficiaries, and Dependents any information it deems necessary for the proper administration of the Plan;

(k) To sue or cause suit to be brought in the name of the Plan, except to the extent such authority has been reserved by the Committee pursuant to its Charter;

(l) To determine the manner in which the assets of this Plan, or any part thereof; will be held, invested, and disbursed; and

(m) Subject to the provisions of Article XI, to establish a claims procedure, including a procedure for the review of any claims denied by an Administrative Provider.

13.6 Committee Procedure

A majority of the members of the Committee as constituted at any time will constitute a quorum, and any action by a majority of the members present at any meeting, or authorized by a majority of the members in writing without a meeting, will constitute the
The Committee may designate certain of its members as authorized to execute any document or documents on behalf of the Committee and may designate certain Employees of the Company to act on behalf of the Plan. The Company, Covered Persons, beneficiaries, and any other party dealing with the Committee may accept and rely upon any document executed by such designated members as representing action by the Committee until the Committee revokes such authorization.

13.7 Compensation of Committee and Plan Expenses

Members of the Committee will serve as such without compensation unless the Company will otherwise determine, but in no event will any member of the Committee who is an employee receive compensation from the Plan for his services as a member of the Committee. All members will be reimbursed for any necessary expenditures incurred in the discharge of duties as members of the Committee. The compensation or fees, as the case may be, of all officers, agents, counsel, or other persons retained or employed by the Committee will be approved by the Committee. The expenses incurred in the administration and operation of the Plan, including but not limited to the expenses incurred by the members of the Committee in exercising their duties, will be borne by the Plan, provided that the Company may pay such expenses on behalf of the Plan.

13.8 Resignation and Removal of Members

Any member of the Committee may resign at any time by giving written notice to the Committee Chairman and to the Company’s Senior Vice President of Human Resources, effective as therein stated. The Committee Chairman may be removed from the Committee or from the position of chairman, at any time, by the Senior Vice President of Human Resources. Any other member of the Committee may, at any time, be removed by the Senior Vice President of Employee Benefits or by the Chairman. If a member of the Committee who is an employee terminates employment, such person will no longer be a member of the Committee.

13.9 Committee Membership Changes

Upon the death, resignation or removal of the Chairman, the Senior Vice President of Human Resources will appoint a successor. Upon the death, resignation or removal of any other Committee member, the Chairman or the Senior Vice President of Human Resources will appoint a successor. Upon termination, for any reason, of a Committee member’s status as a member of the Committee, such member’s status as a named fiduciary will concurrently be terminated, and upon the appointment of a successor Committee member such successor will assume the status of a named fiduciary.

13.10 Records

The Committee will keep a record of all its proceedings and will keep, or cause to be kept, all such books, accounts, records or other data as may be necessary or advisable in its judgment for the administration of the Plan and properly to reflect the affairs thereof.
13.11 Reliance Upon Documents and Opinions

The members of the Committee, the Company, and any person delegated under the provisions of this Plan to carry out any fiduciary responsibilities under the Plan (hereinafter a “delegated fiduciary”), will be entitled to rely upon any tables, valuations, computations, estimates, certificates and reports furnished by any consultant, or firm or corporation which employs one or more consultants, and upon any opinions furnished by legal counsel. The members of the Committee, the Company, and any delegated fiduciary will be fully protected and will not be liable in any manner whatsoever for anything done or action taken or suffered in reliance upon any such consultant or firm or corporation which employs one or more consultants or counsel. Any and all things done or such actions taken or suffered by the Committee, the Company and any delegated fiduciary will be conclusive and binding on all employees, participants, dependents, beneficiaries, and any other persons whomsoever, except as otherwise provided by law. The Committee and any delegated fiduciary may, but are not required to, rely upon all records of the Company with respect to any matter or thing whatsoever, and may likewise treat such records as conclusive with respect to all employees, participants, dependents, and any other persons whomsoever except as otherwise provided by law.

13.12 Requirement of Proof

The Committee or the Company may require satisfactory proof of any matter under this Plan from or with respect to any Employee, Participant, beneficiary, or Dependent, and no such person will acquire any rights or be entitled to receive any benefits under this Plan until such satisfactory proof will be furnished as so required.

13.13 Reliance on Committee Memoranda

Any person dealing with the Committee may rely on and will be fully protected in relying on a certificate or memorandum in writing signed by a majority of members of the Committee, as constituted as of the date of such certificate or memorandum, or by the Senior Vice President of Human Resources if such certificate or memorandum specifically states that it is made on behalf of the Committee, as evidence of any action taken or resolution adopted by the Committee.

13.14 Multiple Fiduciary Capacity

Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

13.15 Indemnification

To the fullest extent permitted by law, the Company will indemnify and hold each member of the Committee, and any other employee of the Company with duties under the Plan, harmless from and against any and all costs, liabilities, damages, and expenses (including any attorney’s fees and any amount paid in settlement) reasonably incurred by him in connection with any claims against him by reason of the performance of his duties under the Plan, unless he has been found guilty, in a final nonappealable order by a court of competent jurisdiction, of willful misconduct in the performance of such duties. The foregoing right of indemnification will be in addition to any other right to
which any such Committee member or other person may be entitled as a matter of law or otherwise.

13.16 Bonding

Except as is prescribed by the Committee or as provided in section 412 of ERISA, or as may be required under any other applicable law, no bond or other security will be required by any member of the Committee, or any other fiduciary under this Plan.

13.17 Administrative Provider

The Committee or Daily Administrator, as applicable, may select and appoint one or more Administrative Providers. Subject to the direction and ultimate discretion of the Committee or Daily Administrator, as applicable, the Administrative Provider will have the duties and powers necessary to process claims and make payments under the Plan, including the following:

(a) To act under the direction and control of the Committee or Daily Administrator, as applicable;

(b) To receive, review, verify, and investigate all requests for distribution under the Plan;

(c) In its discretion, to decide matters of fact, determine eligibility for benefits, and to determine the amount, manner, and timing of benefit payments under the Plan;

(d) To inform the Committee or Daily Administrator, as applicable, as to the amount and timing of payments for benefits and expenses under the Plan;

(e) To prescribe procedures to be followed by Participants in filing requests for distribution under the Plan;

(f) To secure from the Employer, the Committee, the Daily Administrator, Covered Persons and their beneficiaries, as applicable, any information necessary for the proper processing and payment of distributions under the Plan;

(g) To furnish the Employer, the Committee, and Daily Administrator, as applicable, upon request, with reasonable and appropriate reports with respect to the processing and payment of distributions under the Plan;

(h) To maintain records relating to requests for distribution, processing of distributions, and payment or denial of requests for distribution; and

(i) To do such other acts as may be necessary or requested by the Committee or Daily Administrator, as applicable, to handle the processing and payment of distributions under the Plan;

provided, however, that the Administrative Provider will have only those powers specifically designated by the Committee or Daily Administrator, as applicable, and set forth in the applicable Administrative Agreement.
13.18 Plan Design

The Company will have complete authority over all so-called settlor functions, including Plan design decisions, amount and type of benefits, and level of Participant contributions. However, the Company may delegate all or any portion of such authority to its agents, including the Human Resources or the Health and Welfare Benefits Departments of the Company.

13.19 Investment Manager

The Company or Committee may appoint one or more Investment Managers, as defined in section 3(38) of ERISA, to manage all or a portion of the assets of the Plan. An Investment Manager will discharge its duties in accordance with applicable law and in particular in accordance with section 404(a)(1) of ERISA. An Investment Manager, when appointed, will have full power to manage the assets of the Plan for which it has responsibility, and neither the Company nor the Committee will thereafter have any responsibility for the management of such assets. An Investment Manager will serve at the pleasure of the Company or Committee and the Company or Committee will be entitled to remove an Investment Manager at any time.

End of Article XIII
ARTICLE XIV — MANAGEMENT OF FUNDS

14.1 Establishment of Trust

To the extent either required by ERISA or other applicable law, or so desired by the Company, the Company may establish a trust to hold some or all of the assets of the Plan. The trustee of any trust established pursuant to this Section 14.1 will be appointed by either the Company or the Committee.

14.2 Powers and Duties

The powers of any trustee appointed pursuant to Section 14.1 above will be set forth in a trust agreement.

14.3 Funding Policy and Method

The Committee will have the responsibility for providing a procedure for establishing and carrying out a “funding policy and method” for the Plan consistent with the objectives of the Plan and the requirements of ERISA.

14.4 Management of Assets

Except as specifically provided in a trust agreement governing a trust established pursuant to Section 14.1, the Committee will have responsibility with respect to control or management of the Plan assets.

14.5 Mistake of Fact Contributions

In the case of any contribution of the Company to a trust established pursuant to Section 14.1 which is made by reason of mistake of fact, the excess of such contribution over the amount that would have been contributed had there not occurred a mistake of fact will be repaid to the Company, in whole or in part, within one year after the payment of contribution. With respect to contributions made to a trust established pursuant to Section 14.1 by reason of mistake of fact, (a) earnings attributable to the excess contribution will not be returned to the Company, and (b) losses attributable thereto will reduce the amount to be repaid.

End of Article XIV
ARTICLE XV — RESTRICTIONS REGARDING PROTECTED HEALTH INFORMATION

15.1 Purpose of Article

The purpose of this Article XV is to cause the Plan (a) to adopt restrictions on uses and disclosures of PHI by the Company, (b) to provide for other rules and restrictions necessary for the Plan to comply with applicable laws regarding the privacy of PHI, and (c) to establish disciplinary rules regarding violations of the privacy requirements regarding PHI or of the Plan’s privacy policies and procedures. This Article XV is to be construed and interpreted in accordance with such purposes.

15.2 Scope of Article

The Plan is a “hybrid entity,” as such term is defined in section 164.504 of the HIPAA Regulations which requires among other things that (a) the Plan designate those of its components that constitute “health care components,” as such term is defined in section 164.504 of the HIPAA Regulations, (b) document such designation as required pursuant to section 164.530(j) of the HIPAA Regulations and (c) establish adequate separation between such health care components and the non-health care components as required by section 164.504 of the HIPAA Regulations. The terms of this Article XV will only apply with respect to the designated Health Care Components of the Plan identified in Section 1.1(mm) of the Plan. References in this Article XV to the “Plan” will be deemed to be a reference to the Health Care Components of the Plan, including any other group health plans or plans providing “health care” within the meaning of HIPAA that (i) are sponsored by the Company and (ii) provide that they will constitute, or have been designated by the Committee as constituting, along with the Health Care Components of the Plan, a single covered entity for purposes of compliance with the Privacy Rules and the HIPAA Regulations. In addition, certain capitalized terms used in this Article that are not defined herein will have the meaning ascribed to such terms under the HIPAA Regulations.

15.3 Provision of PHI to the Company Pursuant to an Authorization

The Plan may at any time disclose to and the Company may use and disclose PHI received from the Plan if such disclosure and use is pursuant to and in accordance with a valid authorization from the individual who is the subject of such information.

15.4 Provision of SHI or Enrollment Information to the Company

The Company may receive, use, and disclose PHI from the Plan if the information consists solely of SHI and only if the Company certifies to the fiduciaries of the Plan (i.e., the Committee) that the information is being requested for one or more of the following:

(a) For the purpose of enabling the Company to obtain premium bids from health insurers for providing health insurance coverage under the Plan;

(b) For purposes of determining whether and, if so, how to modify or amend the Plan;

(c) For purposes of determining whether and, if so, how to terminate the Plan, in whole or in part; or
(d) For such other purposes consistent with the HIPAA Regulations as may be necessary for the administration of the Plan.

The Company may receive, use, and disclose PHI from the Plan if the information consists of enrollment or disenrollment information (i.e., indicates whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan).

15.5 General Provision of PHI to the Company

The Company may receive PHI from the Plan and use such PHI if (a) the Company certifies in writing to the Plan's fiduciaries (i.e., the Committee) that the Plan incorporates the restrictive provisions described in items (i) through (x) below and the separation requirements described in Section 15.6, and (b) except as described in Sections 15.3 and 15.4, the Company agrees to comply with the following restrictions and requirements regarding the PHI that is provided by the Plan to the Company:

(i) The Company will not use or further disclose the information other than as permitted or required by the Plan documents or as required by law or the HIPAA Regulations as set forth in the Privacy Manual;

(ii) The Company will ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such information;

(iii) The Company will not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;

(iv) The Company will report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(v) The Company will make available to Covered Persons PHI in accordance with section 164.524 of the HIPAA Regulations as set forth in the Privacy Manual;

(vi) The Company will agree to requests by Covered Persons to restrict the use or disclosure of PHI as required by HIPAA or the HIPAA Regulations and as set forth in the Privacy Manual;

(vii) The Company will provide Covered Persons with the right to amend their PHI and will incorporate any amendments to Covered Persons’ PHI in accordance with section 164.526 of the HIPAA Regulations as set forth in the Privacy Manual;

(viii) The Company will provide Covered Persons with an accounting of disclosures of their PHI for reasons other than treatment, payment or health care operations or pursuant to an authorization in accordance with
section 164.528 of the HIPAA Regulations as set forth in the Privacy Manual;

(ix) The Company will make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Regulations;

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

(xi) The Company will ensure the adequate separation required pursuant to Section 15.6; and

(xii) The Company will notify the Plan of any “Breach” (as defined in section 13400(1) of the Health Information Technology for Economic and Clinical Health Act of 2009) by the Company or an agent of the Company without unreasonable delay and in no case later than sixty (60) calendar days of the discovery of the Breach.

15.6 Adequate Separation

At all times, there will be adequate separation between (a) the Plan and the Company and (b) the Health Care Components and the Non-Health Care Components in accordance with the requirements imposed pursuant to section 164.504(f)(2)(iii) and section 164.504(c)(2) of the HIPAA Regulations. In order to comply with such adequate separation requirements:

(i) Except as described in Sections 15.3 and 15.4, the only employees, classes of employees or other persons under the control of the Company to be given access to PHI disclosed to the Company or who receive PHI relating to treatment or payment under the health care operations of, or other matters pertaining to the health care components of, the Plan in the ordinary course of business are: (A) those individuals employed by or providing services to the Company's Corporate Health and Welfare Department which deals with the administration, enrollment and processing of benefit claims under the health care components of the Plan, (B) the Plan's fiduciaries (i.e., the members of the Committee), (C) the Plan's Privacy Officer, (D) the Plan's Contact Person, and (E) the Company's internal legal counsel. In addition, those employees providing services to the Company's Payroll or Human Resources Departments may receive information as to whether an individual is enrolled in the Plan, the benefit options selected by the individual under the Plan and information as to when the individual disenrolls from the Plan.

(ii) The access to and use by the Company and the individuals described in item (i) above is restricted to (A) the Plan administration functions that the
Company performs in connection with the operation and administration of the Health Care Components of the Plan (including, but not limited to, assisting employees, spouses or dependents with enrollment or claims issues, negotiating with Administrative Providers, obtaining payment for benefits under the Plan, and procuring or obtaining reimbursement under a stop-loss insurance policy with respect to the Plan), (B) the plan sponsor functions with respect to which the Company is entitled to receive SHI pursuant to Section 15.4, (C) uses and disclosures described in an authorization by the Covered Person, and (D) uses and disclosures that are described to Covered Persons in the “Notice of Privacy Practices for Tenet Employee Benefit Plan Participants and Their Covered Spouse and Dependents,” as required by section 164.520 of the HIPAA Regulations.

(iii) In the event that any person described in item (i) of this Section 15.6 fails to comply with any of the requirements of this Section 15.6 or of Section 15.5, the noncompliance will be reported to the Privacy Officer in a report describing the name of the noncompliant person and a summary of the details regarding such person’s noncompliance. Upon receipt of such report, the Privacy Officer will solicit a response from the person who has been reported as noncompliant, giving such person the opportunity to contest the charge of noncompliance or to offer justification or other reasons why sanctions should not be imposed with respect to the noncompliance. The Privacy Officer will, after considering all details, facts and circumstances relating to an alleged act of noncompliance for which sanctions may be imposed pursuant to this item (iii), determine if a sanction should be imposed (which sanction may range from a warning to recommended dismissal from employment). Upon determination of a sanction and if the sanction may be imposed under the authority of the Privacy Officer, the sanction will be imposed. If the sanction requires action of the Company, the Privacy Officer will confer with the appropriate managers of the Company. If the Company, following consideration of a proposed sanction from the Plan’s Privacy Officer for noncompliance with the requirements of Sections 15.5 and 15.6 by a person or entity, determines not to impose such sanction, the Company will advise the Privacy Officer. In such event, the Privacy Officer must consider and propose an alternative sanction for the noncompliant person or entity.

15.7 Privacy Officer

The Committee will appoint a Privacy Officer for the Plan. The Committee may remove the Plan’s then existing Privacy Officer at any time upon written notice provided that the Committee has appointed a successor Privacy Officer to serve. The Plan’s Privacy Officer’s duties and responsibilities focus upon the operation and administration of the Plan in connection with HIPAA and the HIPAA Regulations (including activities conducted via the services of insurers, Business Associates, and employees and agents of the Company) and the activities of the Company regarding the Plan in its capacity as sponsor of the Plan. In order to carry out such general powers, duties and responsibilities, the Plan’s Privacy Officer will have the following specific powers, duties and responsibilities:
(a) To develop and propose to the Plan fiduciaries (i.e., the Committee) a comprehensive privacy policy for the Plan which when finalized will be set forth in the Privacy Manual.

(b) To perform initial and periodic privacy risk assessments with respect to the Plan.

(c) To develop and maintain appropriate authorization forms, information notices and materials reflecting the Plan's legal practices and requirements regarding the privacy of PHI.

(d) To develop and implement initial and ongoing privacy training and orientation to all employees of the Company who may have access to PHI in connection with the Plan.

(e) To oversee the development, implementation and ongoing compliance of all Business Associate agreements with the Plan.

(f) To establish with Company management and operations a mechanism to identify all of the Company's plans and benefit arrangements which are “covered entities” for purposes of the laws governing PHI.

(g) To establish rules to determine when to allow Covered Persons to review or receive a report on their PHI privacy activity under the Plan.

(h) To work cooperatively with the Company's Health and Welfare Department, other applicable Company offices/personnel and Business Associates in overseeing Covered Persons' rights to inspect, amend and restrict access to their PHI when appropriate.

(i) To establish and administer a complaint procedure pursuant to which Covered Persons may redress alleged violations of their privacy rights.

(j) To apply sanctions for a failure to comply with the privacy provisions of the Plan, the terms of the Privacy Manual, HIPAA or the HIPAA Regulations as specified in this Article XV.

(k) To review system-related information security plans maintained by the Company to the extent necessary or appropriate.

(l) To serve as information privacy consultant to the Company with respect to the Plan.

15.8 Contact Person

As provided in the Privacy Manual, the Committee will appoint a Contact Person (which may be the same individual or entity as is serving as the Privacy Officer). The Committee may remove the Plan's then existing Contact Person at any time upon written notice provided that if the Committee has not appointed a successor Contact Person to serve, the Privacy Officer will serve as the Contact Person. The Contact Person will have the duties and responsibilities set forth in the Privacy Manual.
15.9 Disciplinary Proceedings

The purpose of this Section 15.9 is to establish appropriate disciplinary sanctions and proceedings as required by the HIPAA Regulations.

(a) Any complaint brought pursuant to the Plan’s complaint procedures which involves an alleged failure to comply with HIPAA, the HIPAA Regulations, the terms of this Article XV or the Privacy Manual will be referred to the Privacy Officer for consideration as to disciplinary sanctions and proceedings under this Section 15.9.

(b) Similarly, if the Privacy Officer becomes aware of any other failure to comply with HIPAA, the HIPAA Regulations, the terms of this Article XV or the Privacy Manual, the Privacy Officer will consider whether such matter is appropriate for disciplinary sanctions and proceedings under this Section 15.9.

(c) If the complaint or other failure involves the actions of a Business Associate, the appropriate disciplinary sanctions and proceedings will be conducted under the terms of the Business Associate agreement. If the complaint or other failure involves the actions of the individuals responsible for the administration of the Plan identified in Section 15.6(i), the appropriate disciplinary sanctions and proceedings will be conducted under Section 15.6(iii). If the complaint or other failure involves the actions of any other Company employee or any agent of the Company, the appropriate disciplinary sanctions and proceedings will be conducted under this Section 15.9.

(d) In the case of either an unresolved complaint or other failure described in (a), the Privacy Officer will solicit a response from the person or agent who has been reported as noncompliant, giving the person or agent the opportunity to contest the charge of noncompliance or to offer justification or other reasons why disciplinary sanctions should not be imposed with respect to the noncompliance.

(e) The Privacy Officer will, after considering all details, facts and circumstances relating to such an alleged act of noncompliance, determine if a disciplinary sanction is warranted (which sanction may range from a warning to dismissal from employment, or in the case of an agent, termination of the agency agreement). Upon determination of a disciplinary sanction and if the sanction may be imposed under the authority of the Privacy Officer, the disciplinary sanction will be imposed.

(f) If the disciplinary sanction requires approval of the Company, the Privacy Officer will confer with the appropriate managers of the Company. If the Company, following consideration of a recommended disciplinary sanction from the Privacy Officer, determines not to impose such disciplinary sanction, the Company will advise the Privacy Officer. In such event, the Privacy Officer must consider and propose an alternative disciplinary sanction for the noncompliant person or agent. The Privacy Officer will ensure that the imposed disciplinary sanction is adequately communicated to the violator and is enforced.

(g) In the event that a disciplinary sanction triggers any rights of appeal (for instance, under a collective bargaining agreement), all such rights of appeal will be
available to the violator. In the case of any such appeal proceedings, the identity of the individual whose privacy rights were violated will be removed to the extent feasible.

15.10 Implementation Authority

The Company will have the authority to enter into and enforce on behalf of the Plan such contracts and agreements (including, specifically, Business Associate agreements) as may be appropriate or necessary to cause the Plan to satisfy its obligations under HIPAA and the HIPAA Regulations.

15.11 Indemnification

The Company will indemnify and hold harmless each employee of the Company who is identified in Section 15.6 as a person who is to be given access to or receive PHI against any and all expenses and liabilities arising out of such employee's administrative functions or fiduciary responsibilities in connection with violations of HIPAA and the HIPAA Regulations, including but not limited to, any expenses and liabilities that are caused by or result from an act or omission constituting the negligence of such employee in the performance of such functions or responsibilities, but excluding expenses and liabilities arising out of such employee's own gross negligence or willful misconduct. Expenses against which such person will be indemnified include, but are not limited to, the amounts of any settlement, judgment, costs, counsel fees, and related charges reasonably incurred in connection with a claim asserted or a proceeding brought. This Section 15.11 will not, however, apply to, and the Company will not indemnify against, any expense that was incurred without the consent or approval of the Company, unless such consent or approval has been waived in writing by the Company. This Section will also not apply to any sanctions or disciplinary action imposed pursuant to Section 15.9.

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End of Article XV
ARTICLE XVI – SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

16.1 Purpose of Article

The purpose of this Article XVI is to (a) cause the Plan to implement security measures designed to ensure the confidentiality, integrity, and availability of all ePHI created, received maintained, or transmitted to or by the Plan, (b) cause the Plan to require that the Company will reasonably and appropriately safeguard ePHI created, received maintained, or transmitted to or by the Company on behalf of the Plan, and (c) establish the office of Security Officer, who will be responsible for the Plan's Security Standards compliance. This Article XVI is to be construed and interpreted in accordance with such purposes.

16.2 Scope of Article

The Plan is a “hybrid entity,” as such term is defined in section 164.504 of the HIPAA Regulations which requires among other things that (a) the Plan designate those of its components that constitute “health care components,” as such term is defined in section 164.504 of the HIPAA Regulations, (b) document such designation as required pursuant to section 164.530(j) of the HIPAA Regulations and (c) establish adequate separation between such health care components and the non-health care components as required by section 164.504 of the HIPAA Regulations. The terms of this Article XVI will only apply with respect to the designated Health Care Components of the Plan identified in Section 1.1(mm) of the Plan. References in this Article XVI to the “Plan” will be deemed to be a reference to the Health Care Components of the Plan, including any other group health plans or plans providing “health care” within the meaning of HIPAA that (i) are sponsored by the Company and (ii) provide that they will constitute, or have been designated by the Committee as constituting, along with the Health Care Components of the Plan, a single covered entity for purposes of compliance with the Privacy Rules and the HIPAA Regulations. In addition, certain capitalized terms used in this Article that are not defined herein will have the meaning ascribed to such terms under the HIPAA Regulations.

16.3 Implementation of Security Standards

The Plan will do all of the following in accordance with the HIPAA Regulations:

(a) The Plan will ensure the Confidentiality, Integrity, and Availability of all ePHI that it creates, receives, maintains or transmits;

(b) The Plan will protect against any reasonably anticipated threats or hazards to the Security or Integrity of such information;

(c) The Plan will protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the Privacy Rules;

(d) The Plan will ensure compliance with the Security Standards by its Workforce;

(e) The Plan will implement each Security Standard and implementation specification thereunder that is designated as “Required” in the HIPAA
Regulations and/or Appendix A to Subpart C of Part 146 thereof, as provided in the Security Manual;

(f) The Plan will take the following steps with regard to each Security Standard and implementation specification thereunder that is designated as “Addressable” in the HIPAA Regulations, as provided in the Security Manual:

(i) The Plan will assess whether each implementation specification in the Security Standard is a reasonable and appropriate safeguard in its environment, when analyzed with reference to the likely contribution to protecting the Plan’s ePHI; and

(ii) As applicable to the Plan, the Plan will implement the implementation specification if reasonable and appropriate or, if implementing the implementation specification is not reasonable and appropriate:

(A) Document why it would not be reasonable and appropriate to implement the implementation specification; and

(B) Implement an equivalent alternative measure if reasonable and appropriate;

(g) The Plan will ensure that its Business Associate contracts comply with the requirements of section 164.314 of the HIPAA Regulations; and

(h) The Plan will periodically review the Security Measures implemented to comply with the Security Standards and modify such measures as needed in order to continue provision of reasonable and appropriate protection of ePHI as described in the Security Manual.

16.4 Provision of Electronic Protected Health Information to the Company

The Company may receive and use ePHI only if (a) the Company certifies to the Plan’s fiduciaries that the Plan has been amended to incorporate the provisions of this Section 16.4, and (b) the Company agrees to comply with and enforce the following restrictions and requirements regarding the ePHI that is provided by the Plan to the Company:

(a) The Company will implement Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan as required by the HIPAA Regulations as set forth in the Security Manual;

(b) The Company will ensure that the adequate separation required pursuant to Section 15.6 is supported by reasonable and appropriate Security Measures as required by the HIPAA Regulations as set forth in the Security Manual;

(c) The Company will ensure that any agent, including a subcontractor, to whom it provides ePHI that it creates, receives, maintains or transmits on behalf of the Plan agrees to implement reasonable and appropriate Security Measures to protect such information; and
(d) The Company agrees to report to the Plan any Security Incident of which it becomes aware in accordance with the HIPAA Regulations as set forth in the Security Manual.

16.5 Implementation of Administrative Safeguards

The Plan will in accordance with section 164.308 of the HIPAA Regulations:

(a) Implement policies and procedures to prevent, detect, contain and correct security violations.

(b) Perform initial and periodic assessments of the potential risks and vulnerabilities to the Confidentiality, Integrity and Availability of ePHI held by the Plan.

(c) Implement Security Measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level.

(d) Develop appropriate sanctions policies and procedures and apply appropriate sanctions against members of the Plan's Workforce who fail to comply with the terms of this Article XVI.

(e) Implement procedures to regularly review records of Information System activity, such as audit logs, access reports, and Security Incident tracking reports.

(f) Implement policies and procedures to ensure that all members of the Plan's Workforce have appropriate access to ePHI, as provided in the Security Manual, and to prevent those Workforce members who do not have access thereunder from obtaining access to ePHI.

(g) Implement policies and procedures for authorizing access to ePHI that are consistent with the applicable requirements of the Privacy Rules.

(h) Implement a security awareness and training program for all members of the Plan's Workforce (including management).

(i) Implement policies and procedures to address Security Incidents.

(j) Identify and respond to suspected or known Security Incidents; mitigate, to the extent practicable, harmful effects of Security Incidents that are known to the Plan; and document Security Incidents and their outcomes.

(k) Establish (and implement as needed) policies and procedures for responding to an emergency or other occurrence that damages systems that contain ePHI.

(l) Establish and implement procedures to create and maintain retrievable exact copies of ePHI.

(m) Establish (and implement as needed) procedures to restore any loss of data.
(n) Establish (and implement as needed) procedures to enable continuation of critical business processes for protection of the security of ePHI while operating in emergency mode.

(o) Perform a periodic technical and nontechnical evaluation, based initially upon the standards implemented under the Security Standards and subsequently in response to environmental or operational changes affecting the security of ePHI, that establishes the extent to which the Plan's security policies and procedures comply with the Security Standards.

(p) Oversee the implementation and compliance of the security provisions of all Business Associate agreements with the Plan, to ensure that the Plan's Business Associates will appropriately safeguard ePHI created, received, maintained or transmitted on behalf of the Plan.

(q) Implement policies and procedures to limit physical access to the Plan's Information Systems and the Facility or Facilities in which they are housed, while ensuring that properly authorized access is allowed.

(r) Review all other Security Standards and implementations specifications that are identified as Addressable under section 164.308 of the HIPAA Regulations and not specifically described above to determine their appropriateness for the Plan and implement the same or a modification thereof.

16.6 Implementation of Physical Safeguards

The Plan will in accordance with section 164.310 of the HIPAA Regulations:

(a) Implement policies and procedures that specify the proper functions to be performed, the manner in which those functions are to be performed, and the physical attributes of the surroundings of a specific Workstation or class of Workstation that can access ePHI.

(b) Implement Physical Safeguards for all Workstations that access ePHI, to restrict access to authorized Users.

(c) Implement policies and procedures that govern the receipt and removal of hardware and electronic media that contain ePHI into and out of the Facility, and the movement of these items within the Facility.

(d) Implement policies and procedures to address final disposition of ePHI, and/or the hardware or Electronic Media on which it is stored.

(e) Implement procedures for removal of ePHI from Electronic Media before the media are made available for re-use.

(f) Review all other Security Standards and implementations specifications that are identified as Addressable under section 164.310 of the HIPAA Regulations and not specifically described above to determine their appropriateness for the Plan and implement the same or a modification thereof.
16.7 Implementation of Technical Safeguards

The Plan will in accordance with section 164.312 of the HIPAA Regulations:

(a) Implement technical policies and procedures for electronic information systems that maintain ePHI to allow access only to those persons or software programs that have been granted access rights in accordance with the Security Standards.

(b) Assign unique names and/or numbers for identifying and tracking the identity of Users of the Plan’s ePHI.

(c) Establish (and implement as needed) procedures for obtaining necessary ePHI during an emergency.

(d) Implement hardware, software, and/or procedural mechanisms that record and examine activity in Information Systems that contain or use ePHI.

(e) Implement policies and procedures to protect ePHI from improper alteration or destruction.

(f) Implement procedures to verify that a person or entity seeking access to ePHI is the one claimed.

(g) Implement technical Security Measures to guard against unauthorized access to ePHI that is being transmitted over an electronic communications network.

(h) Review all other Security Standards and implementations specifications that are identified as Addressable under section 164.312 of the HIPAA Regulations and not specifically described above to determine their appropriateness for the Plan and implement the same or a modification thereof.

16.8 Implementation of Policies and Procedures and Documentation Requirements

The Plan will in accordance with section 164.316 of the HIPAA Regulations:

(a) Implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications, or other requirements of the Security Standards, taking into account (i) the size, complexity, and capabilities of the Plan, (ii) the Plan’s technical infrastructure, hardware, and software security capabilities, (iii) the costs of the Security Measures, and (iv) the probability and criticality of potential risks to ePHI.

(b) Maintain in written or electronic form the policies and procedures implemented by the Plan to comply with the provisions of this Article XVI as required by the Security Standards.

(c) Maintain in written or electronic form records of any actions, activities or assessments taken by the Plan that are required by this Article XVI or the Security Standards to be so maintained.
(d) Retain the documentation required by this Article XVI for a period of six (6) years from the date of its creation or the date when it was last in effect, whichever is later.

(e) Make the documentation required by this Article XVI available to those members of the Plan's Workforce responsible for implementing such policies and procedures.

(f) Periodically review the Plan policies and procedures and update them as needed in response to environmental or operational changes affecting the security of ePHI.

16.9 Security Officer

The Committee will appoint a Security Officer for the Plan. The Committee may remove the Plan's then existing Security Officer at any time upon written notice provided that the Committee has appointed a successor Security Officer to serve. The Plan's Security Officer's duties and responsibilities focus upon the operation and administration of the Plan in connection with the Security Standards, HIPAA, and the HIPAA Regulations (including activities conducted via the services of insurers, Business Associates, and employees and agents of the Company) and activities of the Company regarding the Plan in its capacity as sponsor of the Plan.

16.10 Implementation Authority

The Company will have the authority to enter into and enforce on behalf of the Plan such contracts and agreements (including, specifically, Business Associate agreements) as may be appropriate or necessary to cause the Plan to satisfy its obligations under HIPAA and the HIPAA Regulations.

16.11 Indemnification

The Company will indemnify and hold harmless each member of the Plan's Workforce who has access to or receive ePHI against any and all expenses and liabilities arising out of such employee's administrative functions or fiduciary responsibilities in connection with violations of HIPAA and the HIPAA Regulations, including but not limited to, any expenses and liabilities that are caused by or result from an act or omission constituting the negligence of such employee in the performance of such functions or responsibilities, but excluding expenses and liabilities arising out of such employee's own gross negligence or willful misconduct. Expenses against which such person will be indemnified include, but are not limited to, the amounts of any settlement, judgment, costs, counsel fees, and related charges reasonably incurred in connection with a claim asserted or a proceeding brought. This Section 16.11 will not, however, apply to, and the Company will not indemnify against, any expense that was incurred without the consent or approval of the Company, unless such consent or approval has been waived in writing by the Company.

End of Article XVI
ARTICLE XVII — FMLA COVERAGE

17.1 FMLA Compliance

To the extent required by the FMLA, each Health Care Component that is a group health plan within the meaning of section 5000(b)(1) of the Code or section 607(1) of ERISA (i.e., the Medical Benefit Program component (includes all insured and self-funded medical benefits provided), the Dental Benefit Program component, the Vision Benefit Program component, and the Health Care Spending Account component) will provide for continuation of coverage and reinstatement of coverage for a Participant and his eligible Covered Dependents if such Participant takes a leave of absence from the Employer pursuant to the rights afforded him under the FMLA and complies with the requirements imposed upon him under the FMLA and Section 3.6 of this Plan as a condition to such rights. The provisions of this Article XVII will supersede and entirely replace any provisions regarding requirements under the FMLA which are in a Component Program Document to the extent that such provisions in the Component Program Document conflict with this Article XVII.

End of Article XVII
ARTICLE XVIII — USERRA

18.1 USERRA Compliance

To the extent required by USERRA, each Health Care Component that is a “health plan,” as defined by section 4303(7) of USERRA (i.e., a Health Care Component providing health services), will provide for continuation of coverage and reinstatement of coverage for a Participant and his eligible Covered Dependents if such Participant takes a leave of absence from the Employer for “services in the uniformed services,” as defined by section 4303(13) of USERRA and complies with the requirements imposed upon him under USERRA and Section 3.6 of this Plan. The provisions of this Article XVIII will supersede and entirely replace any provisions regarding requirements under USERRA which are in a Component Program Document to the extent that such provisions in the Component Program Document conflict with this Article XVIII.

End of Article XVIII
ARTICLE XIX — AMENDMENT AND TERMINATION OF PLAN

19.1 Right to Amend

Benefits under the Plan are neither “vested” nor “accrued.” The Company, acting either through its Board of Directors or any authorized officer, expressly reserves the right to amend, modify or discontinue the Plan at any time, thereby to terminate any rights, benefits or claims under the Plan which had not actually been incurred as of the date of such amendment, modification or termination. In addition, the Committee and the Daily Administrator, may amend the Plan if such amendment either (a) is deemed necessary or appropriate to comply with applicable law, or (b) does not have a material adverse cost affect on the Company. Any oral statements or representations made by the Employer, an Administrative Provider, or any other individual or entity that alter, modify, amend, or are inconsistent with the written terms of the Plan will be invalid and unenforceable and may not be relied upon by any Participant, Employee, beneficiary, Dependent, service provider, or other individual or entity.

19.2 Right to Terminate; Automatic Termination

The Employer hopes and expects to continue the Plan. However, notwithstanding any provision of any other communication, either oral or written, made by the Employer, the Committee, an Administrative Provider, or any other individual or entity to employees, to any service provider, or to any other individual or entity, the Company reserves the absolute and unconditional right to terminate the Plan and any Component Programs, in whole or in part, on behalf of itself and each Participating Employer.

19.3 Effect of Amendment or Termination

If the Plan is amended or terminated, each Covered Person and beneficiary will have no further rights hereunder and the Employer will have no further obligations hereunder, except as otherwise specifically provided under the terms of the Plan and each Component Program; provided, however, that no modification, alteration, amendment, suspension, or termination will be made that would diminish any vested accrued benefits arising from incurred but unpaid claims of Covered Persons or beneficiaries existing prior to the effective date of such modification, alteration, amendment, suspension, or termination.

19.4 Merger or Consolidation

If the Employer does not survive any dissolution, merger, consolidation, or reorganization, the Plan will terminate with respect to the Employer and its employees unless the Plan is continued by the successor to the Employer and such successor agrees to be bound by the terms and conditions of the Plan.

End of Article XIX
ARTICLE XX — MISCELLANEOUS PROVISIONS

20.1 No Guarantee of Employment

Nothing herein will alter the presumption of employment at will. Nothing herein will be construed to be a contract between the Employer and an Employee, or to be consideration for or an inducement of the employment of any Employee by the Employer. Nothing herein will grant any Employee the right to be retained in the service of the Employer or limit in any way the right of the Employer to discharge or terminate the service of any Employee at any time, without regard to the effect such discharge or termination may have on any rights under the Plan.

20.2 Assignment and Payment of Benefits

Rights and benefits under the Plan will not be assignable, either before or after services and supplies are provided; provided, that a Participant or Covered Dependent may direct that benefit payments be made directly to a medical provider. Further, in the absence of a written agreement with a Provider, the Plan reserves the right to make benefit payments to the provider or the Participant or Covered Dependent. Payment to either party discharges the Plan's responsibility to the Participant or Covered Dependents for benefits available under the Plan. The fact that benefit payment is directed or made directly to the Provider will not give the Provider status as a Participant, and any dispute regarding the amount of such payment must be resolved by the Participant through the Plan's internal claims procedure (i.e., the Provider may not invoke the internal claims procedure on behalf of the Participant or Covered Dependent). In addition, once covered services have been rendered by a Provider, the Participant or Covered Dependent has no right to request that the Plan not pay such provider.

20.3 Payments to Minors and Incompetents

If a Covered Person entitled to receive any benefits under the Plan is a minor, is determined by the Committee to be incompetent, or is adjudged by a court of competent jurisdiction to be legally incapable of giving valid receipt and discharge for benefits provided under the Plan, the Committee may pay such benefits to the duly-appointed guardian or conservator of such person or to any third party who is authorized (as determined by the Committee) to receive any benefit under the Plan for the Covered Person. Such payment will fully discharge all liabilities and obligations of the Committee under the Plan with respect to such benefits.

20.4 No Vested Right to Benefits

No Covered Person nor anyone claiming through such Covered Person will have any right to or interest in any benefits hereunder, except as specifically provided herein.

20.5 Non-alienation of Benefits

Except as provided in Section 3.5(d) (regarding QMCSO coverage), Section 20.8 (regarding incorrect information), Section 20.2 (regarding assignment and payment of benefits) and Section 20.10 (regarding reimbursement for excess benefit payments), or
except as the Committee may otherwise permit by rule or regulation, no interest in or benefit payable under the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt by a Covered Person to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge the same will be void and of no effect; nor will any interest in or benefit payable under the Plan be in any way subject to any legal or equitable process, including garnishment, attachment, levy, seizure, or lien. This provision will be construed to provide each Covered Person, or other person claiming any interest or benefit in the Plan through a Covered Person, with the maximum protection afforded such Covered Person’s interest in the Plan (and benefits thereunder) by law against alienation or encumbrance, and against any legal and equitable process, including attachment, garnishment, levy, seizure, or lien.

20.6 Unknown Whereabouts

Each Participant will inform the Committee or its delegate of his current mailing address which will also serve as the current mailing address of his Covered Dependents and beneficiaries. If a Participant fails to inform the Committee of his current mailing address, neither the Committee, any Administrative Provider, nor the Employer will be responsible for any late payment or loss of benefits, nor for failure of any notice to be provided or provided timely under the terms of the Plan to such individual. In addition, any communication, statement or notice addressed to a Participant at the last mailing address provided by such Participant to the Daily Administrator will be binding upon such person for all purposes of the Plan, and the Daily Administrator will not be obligated to search for or ascertain the whereabouts of any such Participant. In the event that the Daily Administrator is unable to locate a Participant or beneficiary to whom a payment is due, that amount will be forfeited.

20.7 Notice and Filing

Any notice, administrative form, or other communication required to be provided to, delivered to, or filed with the Committee will include provision to, delivery to, or filing with any person or entity designated by the Committee to be an agent for the disbursement and receipt of administrative forms and communications. Except as otherwise provided herein, where such provision, delivery, or filing is required, it will be deemed given or made only upon actual receipt of such notice, administrative form, or other communication by the Committee or designee. Unless otherwise provided by law, any notice or other document sent by the Employer, the Committee, or an Administrative Provider will be deemed given or made when deposited in the mail, when entrusted to a courier or delivery service, or when sent by telefax or other electronic means. Any notice required hereunder may be waived by the person entitled to the notice.

20.8 Incorrect Information, Fraud, Concealment, or Error

(a) Recovery Due to Errors. If because of a human or systems error, or because of incorrect information provided by or correct information failed to be provided by fraud, misrepresentation, or concealment of any relevant fact (as determined by the Committee) by any Covered Person, beneficiary, or other individual, the Plan: enrolls any individual in a Component Program; provides continuation coverage pursuant to Article III; pays a claim under the Plan; incurs a liability for failure to
enroll, provide continuation coverage, or pay a benefit claim, or for terminating enrollment or continuation coverage; or makes any overpayment or erroneous payment, the Committee will be entitled to recover from such Covered Person, beneficiary, or other individual the benefit paid or the liability incurred, together with all expenses incidental to or necessary for such recovery. This recovery may be by whatever means the Committee chooses, including by offset against benefits otherwise properly due hereunder.

(b) **No Diminished Right to Benefits.** Human or systems error will not deprive an Employee or a Dependent of coverage or affect the amount of benefits to which a Covered Person or beneficiary is otherwise entitled under the terms of the Plan.

### 20.9 Medical Responsibilities

With regard to Component Programs providing medical and other health-related benefits, all responsibility for medical decisions concerning any treatment, drug, service, or supply for a Covered Person rests with the Covered Person and such person's treating physician. Neither the Employer, the Plan, the Committee, the Daily Administrator nor an Administrative Provider has any responsibility for any such medical decision or for any act or omission of any physician, hospital, pharmacist, nurse, or other provider of medical goods or services; each may rely upon the representations of any physician, hospital, pharmacist, nurse, or other provider of goods or services without any duty to verify independently the truth of such representations. A decision concerning any treatment, drug, service, or supply, or any other decision made by a Covered Person or medical provider, will in no way affect the decision by the Committee or Daily Administrator or its delegate whether a benefit is payable under the Plan with respect to such treatment, drug, service, or supply.

### 20.10 Reimbursement of Company for Excess Benefit Payment

If, due to error or otherwise, an individual receives a benefit payment under this Plan any portion of which is in excess of the benefit, if any, to which the individual may be entitled under the terms of the Component Program Document, such individual will reimburse the Plan or Company for the full amount of the excess benefit payment. Such individual will also hold the Plan and Company harmless for any liability either of them may incur for a failure to withhold federal or state income taxes or payroll taxes from the excess benefit payment. If the individual fails to repay the Company or Plan for the excess benefit payment, the Plan will be entitled to recover such excess benefit payment by reducing the amount of any future benefit payments to which the individual or any member of his family may be entitled under the Plan.

### 20.11 Electronic Administration

The Plan may be administered electronically by use of telephonic and/or computer resources. It is specifically contemplated that, where the Plan refers to communications such as designations, writings, notices, elections, and the like, these communications may occur electronically pursuant to such procedures as the Committee may establish.
20.12 Required Documentation

Whenever the Plan requires or permits a Participant to give notice to the Plan or to the Company, or to make an election or apply for coverage or payment of benefits or otherwise to communicate with the Plan or the Company or representative of either of said parties ("Plan Communication"), the Committee or Daily Administrator may impose reasonable requirements regarding the form and timing of any such Plan Communication including, but not limited to, the use of standard forms, and the imposition of requirements that any such Plan Communication be delivered not less than a reasonable period of time prior to the effective date of any such Plan Communication, and may require the Participant to provide substantiation of information related to Plan participation. Such forms and other requirements, including requirements regarding substantiation of information, may be changed from time to time by the Committee, Daily Administrator or authorized personnel in the Health and Welfare Benefits Department of the Company and such personnel similarly may approve forms or requirements imposed by third parties engaged to provide services to the Plan.

20.13 No Reliance

Benefits under the Plan are payable only to the extent provided by the Plan document and such other documents as are contemplated by this instrument to be a part of this Plan. No Participant or assignee will be entitled to rely on any verification of coverage or description of coverage given or alleged to have been given to such person which is inconsistent with the terms of the Plan.

20.14 Execution of Receipts and Releases

Any payment to or on behalf of any Participant or to his dependent, beneficiary or legal representative ("payee"), in accordance with the provisions of the Plan, will to the extent thereof be in full satisfaction of all claims hereunder against the Plan, Committee, and Company. The Committee may require such payee, as a condition precedent to such payment, to execute a receipt and release therefor in such form as the Committee will determine.

20.15 No Conversion Privilege

Except as provided in an insurance policy which serves as a Component Program Document, Participants will have no right or ability to convert coverage provided under the Plan to an individual policy upon terminating participation in the Plan.

20.16 Addresses, Notices, Waiver or Notice

Each Participant must file with the Daily Administrator (or its authorized agent) in writing his post office address. Any communication, statement or notice addressed to such person at his last post office address as filed with the Daily Administrator will be binding upon such person for all purposes of the Plan, and the Daily Administrator will not be obligated to search for or ascertain the whereabouts of any such person. Any benefit mailed to a Participant at such address may be deemed forfeited by the Participant if not claimed within one year of mailing. Any notice required hereunder may be waived by the person entitled to notice.
20.17 Entire Plan

This document (together with any other documents incorporated by reference herein) constitutes the entire Plan and there are no oral terms or conditions to the contrary. Any change, modification, or amendment to the Plan must be in writing and signed by the Company, Committee, Daily Administrator, or a designated agent thereof, as appropriate.

End of Article XX
APPENDIX A

TENET EMPLOYEE BENEFIT PLAN

Effective January 1, 2017, the following Component Programs, with the exception of the Health Savings Accounts, are incorporated into and made a part of the Plan:

- Medical Benefit Program*
- Dental Benefit Program*
- Employee Assistance Program*
- Disability Benefit Program*
- Long-Term Care Benefit Program*
- Health Care Spending Account*
- Dependent Day Care Spending Account*
- Health Reimbursement Account Program
- Vision Benefit Program*
- Life Benefit Program* - amount ≤ $50 excl. from GI
- AD&D Benefit Program*
- Critical Illness Insurance*
- Accident Insurance *
- Business Travel Accident Benefit Program*
- Health Savings Accounts Established by HSA Eligible Participants***

As provided in Section 1.1(p) of the Plan, this Appendix A may be updated from time to time without a formal amendment to the Plan.

* ERISA Plan Number 515
*** These are individual accounts maintained by Eligible Participants that are not part of the Plan. The Plan simply allows Eligible Participants to make pre-tax contributions to such Health Savings Accounts under the Cafeteria Component Program. As such no Form 5500 reporting is required for the Health Savings Accounts.
APPENDIX B

TENET

IMPORTANT — ACTION NEEDED

This notice must be completed and returned to the MyBenefits Customer Support Center within 31 days or Domestic Partner coverage will be dropped retroactively to the coverage begin date.

CRITERIA FOR DOMESTIC PARTNERSHIP STATUS
(for purposes of obtaining group health plan coverage)

A group health plan sponsored by Tenet for its employees (a “GHP”) that extends coverage to dependents will provide coverage to a “Domestic Partner” (as defined in this Appendix B) of an “Employee,” as defined below, pursuant to the terms and conditions described herein, if all of the applicable requirements are met. This Appendix B may be updated from time to time without formal amendment to the Plan.

PART A - DOMESTIC PARTNERSHIP DEFINED

A Domestic Partnership is defined as follows:

For purposes of the GHPs, a Domestic Partnership consists of an employee of Tenet (“Employee”) and one other person of the same or opposite sex (a “Domestic Partner”). Such persons must satisfy the following requirements:

Each partner must be the other’s sole domestic partner and must intend to remain so indefinitely. The partners must have an exclusive mutual commitment similar to that of marriage and:

(a) Each partner must be at least 18 years of age or, if lower, the age at which a person may be legally married in the state in which the partners share the same permanent address;

(b) The partners must share the same permanent residence and have done so for at least 12 months;

(c) The partners cannot be related by blood to a degree that would prohibit marriage;

(d) The partners cannot be legally married to anyone else or in a domestic partnership with another individual nor have had another domestic partner within the prior six months;

(e) The partners must share the same permanent address and must be able to provide their driver’s licenses listing the common address;

(f) The partners must share joint financial responsibility for basic living expenses, including food, shelter and coverage expenses;

(g) The partners must each be mentally competent to consent to contract; and
The partners must be financially interdependent, demonstrated by at least two of the following:

1. Ownership of a joint bank account; ownership of a joint credit account; or evidence of joint obligation on a loan;
2. Common ownership of a motor vehicle;
3. Joint ownership of a residence; or evidence of a joint mortgage or lease;
4. Evidence of common household expenses, e.g. utility, phone;
5. Execution of wills naming each other as executor and/or beneficiary;
6. Granting each other durable powers of attorney;
7. Designation of each other as beneficiary under a retirement benefit account; or
8. Evidence of other joint financial responsibility.

Notwithstanding the foregoing, a Domestic Partner of an Employee will be eligible for coverage under any GHP offering coverage to domestic partners if the Domestic Partnership has been registered with any state or local government registry recognizing domestic partnerships (and the Domestic Partnership meets the requirements of such registry) or if the domestic partners have entered into a legal civil union in any state recognizing civil unions. Effective September 16, 2013, an Employee’s legal same-sex Spouse (as such term is defined in the Tenet Employee Benefit Plan) is eligible for coverage as a Spouse (and not as a Domestic Partner) under any GHP offering Spousal coverage.

**Dependent Children of Domestic Partner include the following individuals:**

Dependent Child(ren) of a Domestic Partner are eligible for coverage under any GHP that provides dependent coverage when they are:

1. Unmarried,
2. Primarily dependent on the Employee for support, and
3. Meet the eligibility requirements of the GHP (including the requirement that such child be the federal tax dependent of the Employee).

**Obtaining Domestic Partner Coverage:**

In order to obtain Domestic Partner coverage, the Employee and Domestic Partner must complete and file with MyBenefits Customer Support Center, the **Affidavit Declaring Domestic Partnership**, attached hereto. Such form must be filed at annual enrollment. If the **Affidavit Declaring Domestic Partnership** is not filed during an annual enrollment period, coverage for the Domestic Partner will not begin until after the next annual enrollment period, unless the Domestic Partner loses other group health coverage during the plan year and is entitled to a mid-year entry under the plan’s HIPAA special enrollment provisions that apply in the case of a loss of other group health coverage. Further, mid-year enrollment of a Domestic Partner as a
Life Event is not permitted by federal law, unless the Domestic Partner qualifies as the Employee’s federal tax dependent.

To the extent that the Domestic Partner has a dependent child or children, such children may be enrolled pursuant to the terms of the GHP at the same time the Domestic Partner is enrolled; provided, the child(ren) satisfy the definition of Dependent Child above. A Dependent Child may also be entitled to mid-year enrollment under the plan’s HIPAA special enrollment provisions that apply in the case of acquisition of a child or a loss of other group health coverage. A Dependent Child may also be entitled to mid-year enrollment on account of a Life Event.

**Termination of a Domestic Partnership:**

(a) Each Employee with a Domestic Partner has an obligation to notify MyBenefits Customer Support Center, by filing the Declaration of Termination of Domestic Partnership (attached hereto), if there is any change in the Domestic Partnership status as attested to in the Affidavit Declaring Domestic Partnership that would terminate such partnership (such as the death of a Domestic Partner, a change in residence of one partner, termination of the relationship, etc.). The Employee must notify MyBenefits Customer Support Center within thirty-one (31) days of such change in the Domestic Partnership.

(b) Upon termination of the Domestic Partnership, the GHP coverage of the Domestic Partner who is not an Employee as well as coverage of any dependent child(ren) of such Domestic Partner will cease, unless the dependent child(ren) continue to satisfy the definition of Dependent Child under the GHP (i.e., are unmarried and primarily dependent on the Employee for support and meet the eligibility requirements of the plan). Termination of such coverage (obtained as a result of completion of the Declaration of Termination of Domestic Partnership) will be effective on the date the relationship ends as indicated on such form.

(c) In the event a Domestic Partnership is terminated for reasons other than death of a Domestic Partner, an Employee cannot re-enroll for Domestic Partnership coverage under any Tenet GHP until 6 months from the date the Domestic Partnership ended.

**COBRA coverage upon termination of Domestic Partnership:**

(a) **Domestic Partner.** Under federal law, COBRA is only available to qualifying employees and their qualifying spouses and dependent children. Thus, a Domestic Partner may not elect COBRA in his or her own right. However, an Employee on COBRA may add a Domestic Partner to a Tenet GHP in the same manner as is permitted for active employees. In the event an Employee who is a COBRA beneficiary dies or becomes Medicare entitled, or the Domestic Partnership is terminated, the Employee’s Domestic Partner (or former Domestic Partner) may not make an election under the Tenet GHP pursuant to COBRA as a second qualifying event.

(b) **Dependent Children.** If dependent coverage of the dependent child(ren) of the Domestic Partner ends under a Tenet GHP because such child(ren) cease to satisfy the definition of Dependent Child under such plan, such child(ren) will be eligible to elect COBRA.
PART B - TAX CONSEQUENCES

Possible Tax Implications of Domestic Partner Coverage:

There may be federal income tax implications associated with providing coverage under a Tenet GHP to domestic partners. For example, if the Domestic Partner does not qualify as your dependent under section 152 of the Internal Revenue Code (determined without regard to sections 152(b)(1), (b)(2), and (d)(1)(B)), the fair market value of the Domestic Partner coverage will be includible in your income as wages for federal income tax purposes. Similar tax implications may apply for state income tax purposes. However, GHP coverage provided to your Domestic Partner may qualify for exclusion from income for state income tax purposes based on state law. Exemption from state income tax is often conditioned on the relationship being registered or the parties having entered into a civil union. It is your responsibility to determine the requirements of your state. Please consult with your tax advisor prior to making a declaration of Domestic Partnership.

Proof of Tax-Qualified Status of Domestic Partnership:

Domestic Partner coverage under Tenet’s GHPs will be provided on an after-tax basis for both federal and state income tax purposes unless you provide proof at the time of enrollment that your Domestic Partner qualifies as your dependent under section 152 (determined without regard to sections 152(b)(1), (b)(2), and (d)(1)(B)) of the Internal Revenue Code for federal income tax purposes or qualifies for pre-tax-coverage under state law. If this proof is not provided at enrollment, your Domestic Partner coverage under Tenet’s GHPs will be provided on an after-tax basis for both federal and state income tax purposes.
AFFIDAVIT DECLARING DOMESTIC PARTNERSHIP
(for purposes of obtaining coverage)

We, ___________________________ ("Employee") and ______________________________
("Domestic Partner") are domestic partners (i.e., have a "Domestic Partnership"). We have
read and understand the above Criteria for Domestic Partnership Status, which summarizes
the eligibility requirements for Domestic Partner coverage under Tenet’s group health plan (a
"GHP").

1. We declare that we meet the applicable eligibility requirements described in Criteria for
Domestic Partnership Status and desire to obtain Domestic Partner coverage under a
Tenet GHP. In the event that the Domestic Partner has a child or children that meet the
definition of Dependent Child described above, we understand that we may also enroll
such child(ren) in the GHP pursuant to its terms. We acknowledge that such Domestic
Partner coverage will not be available if the GHP does not provide dependent coverage.
We further acknowledge in requesting coverage that we will provide to MyBenefits
Customer Support Center satisfactory proof that we qualify as a Domestic Partnership,
as defined in the Criteria for Domestic Partnership Status.

2. We have provided the information required by the Criteria for Domestic Partnership
Status and are signing this Affidavit Declaring Domestic Partnership for use by Tenet
for the sole purpose of determining our eligibility for Domestic Partner benefits under
Tenet’s GHP. We understand and agree that Tenet is not legally required to extend such
benefits. We understand that the information provided in this Declaration of Domestic
Partnership will be treated as confidential by Tenet and the service providers for the
Tenet GHP but will be subject to disclosure; a) upon the express written authorization of
the undersigned Employee or Domestic Partner, b) upon request of the insurer or plan
administrator, or c) if otherwise required by law.

3. We understand that we will be required to reimburse the GHP and/or Tenet for any
benefits paid under the GHP by reason of any false statement contained in this Affidavit
Declaring Domestic Partnership or for failure to timely notify MyBenefits Customer
Support Center of changed circumstances that would terminate this Affidavit Declaring
Domestic Partnership and that Tenet or the GHP may bring a civil action against one
or both of us to recover such amounts (as well as attorneys’ fees and costs). We further
understand that the Employee could be subject to disciplinary action, including discharge
from employment, for falsification of information in this Affidavit Declaring Domestic
Partnership or a failure to notify MyBenefits Customer Support Center of changed
circumstances pursuant to the requirements of this Affidavit Declaring Domestic
Partnership.

4. We certify that the Domestic Partner __ is ___ is not (select one) the Employee’s
dependent within the meaning of section 152 (without regard to sections 152(b)(1),
(b)(2), and (d)(1)(B)) of the Internal Revenue Code. (We understand that to qualify as a
dependent within the meaning of section 152 (without regard to sections 152(b)(1),
(b)(2), and (d)(1)(B)) of the Internal Revenue Code, the Domestic Partner must be an
individual over half of whose support, for the calendar year in which the Employee’s
taxable year begins, was received from the Employee and who, for the Employee’s taxable year has as his or her principal place of abode the Employee’s home and is a member of the Employee’s household. We further understand that to qualify as the Employee’s dependent within the meaning of section 152 (without regard to sections 152(b)(1), (b)(2), and (d)(1)(B)) of the Internal Revenue Code, the relationship between the Employee and Domestic Partner cannot be prohibited by law. (Attached is proof of dependent status)

5. We certify that the Domestic Partner ___ is eligible ___ is not eligible (select one) to receive health coverage on a pre-tax basis under state law. (Attached is proof of such eligibility (e.g., proof of a registered domestic partnership or civil union under state law)).

6. We understand that this Affidavit Declaring Domestic Partnership may have legal implications relating to, for example, ownership of property or taxability of benefits provided. We understand that before signing this Affidavit Declaring Domestic Partnership, we should seek competent legal advice concerning such matters. To the extent that the Domestic Partner qualifies as a dependent (within the meaning of section 152 (without regard to sections 152(b)(1), (b)(2), or (d)(1)(B)) of the Internal Revenue Code, as described in item 4 above) or is eligible to receive health coverage on a pre-tax basis under state law (as described in item 5 above) such that benefits under the GHP may be provided on a pre-tax basis for purposes of federal and/or state law, we have so indicated.

7. We acknowledge that with respect to Tenet’s GHPs, the Employee (and the Domestic Partner in the event that he or she is also an employee of Tenet) will not be permitted to request dependent coverage for a new domestic partner until at least 6 months after this Domestic Partnership has ended (as stated in the Declaration of Termination of Domestic Partnership), except in the event of the death of the Domestic Partner.

8. We acknowledge that we have been advised to consult a tax advisor or our attorney regarding the implications of filing this Affidavit Declaring Domestic Partnership.

Signature—Employee

Signature—Domestic Partner

Date

Date

Printed Name

Printed Name

Employee’s Social Security Number
Subscribed and sworn to me this _____ day of ____________________, 20_____.
Witness my hand and official seal.

[SEAL]

My commission expires: ____________________
Notary Public: ____________________________

Mail form to:
MyBenefits Customer Support Center
100 Half Day Road
P.O. Box 1552
Lincolnshire, Illinois 60069-1552

This Appendix B may be updated from time to time without formal amendment to the Plan.
DECLARATION OF TERMINATION OF DOMESTIC PARTNERSHIP FORM

I, _______________________________ (the “Employee”), certify and declare that (the “Former Domestic Partner”) and I are no longer domestic partners as of __/__/__ (the “Termination Date”).

I understand that coverage under Tenet’s group health plan (the “GHP”) for the Former Domestic Partner will terminate effective as of the Termination Date.

1. I make and file this Declaration of Termination of Domestic Partnership in order to cancel the Affidavit Declaring Domestic Partnership filed with Tenet on __/__/__.

2. Termination of the Affidavit Declaring Domestic Partnership is due to:

   ___ Termination of domestic partnership
   ___ No longer jointly responsible for each other’s common welfare and living expenses
   ___ Death of domestic partner

I understand that with respect to any of Tenet’s GHPs another Affidavit Declaring Domestic Partnership cannot be filed until six (6) months from the date the relationship ends (as indicated above) except with respect to death of my Former Domestic Partner.

In the event that termination of this relationship is not due to the death of my Former Domestic Partner, I will mail my Former Domestic Partner a copy of this notice to the following address:

___________________________________
___________________________________
___________________________________
(Former Domestic Partner new address)

I affirm, under penalty of perjury, that the above statements are true and correct.

___________________________________  __/__/__  __/__/__
Signature of Employee            Date of Birth    Date

___________________________________
Printed name

Mail form to:

MyBenefits Customer Support Center
100 Half Day Road
P.O. Box 1552
Lincolnshire, Illinois 60069-1552

This Appendix B may be updated from time to time without formal amendment to the Plan.
## APPENDIX C
### TENET EMPLOYEE BENEFIT PLAN

Effective January 1, 2017, the following Affiliates are not Participating Employers in the Plan.

<table>
<thead>
<tr>
<th>AFFILIATE</th>
<th>EFFECTIVE DATE OF NON-PARTICIPATION IN PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olive Branch Urgent Care, LLC</td>
<td>December 27, 2016</td>
</tr>
<tr>
<td>West Boynton Urgent Care, LLC</td>
<td>December 27, 2016</td>
</tr>
<tr>
<td>NUCH of Texas</td>
<td>December 27, 2016</td>
</tr>
<tr>
<td>NUCH of Michigan, Inc.</td>
<td>December 27, 2016</td>
</tr>
<tr>
<td>NUCH of Massachusetts</td>
<td>December 27, 2016</td>
</tr>
<tr>
<td>NUCH of Georgia, LLC</td>
<td>December 27, 2016</td>
</tr>
</tbody>
</table>

As provided in Section 1.1(ggg) of the Plan, this Appendix C may be updated from time to time without a formal amendment to the Plan.