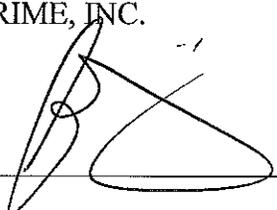


Accident Insurance	Insured	Trustmark
Worksite Critical Illness	Insured	Trustmark

IN WITNESS WHEREOF, the Employer hereby adopts this Amendment effective as of the date set forth herein.

NEW PRIME, INC.

By  \_\_\_\_\_

Title Human Resources Director

Date 3/14/18

**APPENDIX III**

**COMPONENT DOCUMENTS**

*(Updated effective January 1, 2017)*

The terms, conditions and limitations of the benefits described in Article III of the Plan are contained in the Component Documents listed from time to time in this Appendix III, which are incorporated herein by reference.

<b>Component Program</b>	<b>Insured or Self-Insured</b>	<b>Insurance Carrier or Administrator</b>
Medical (includes HSA/HDHP option)	Self-Insured	RightChoice Managed Care, Inc. dba Anthem Blue Cross and Blue Shield (“Anthem”)
Dental	Insured	Anthem BlueCross and BlueShield
Vision	Insured	(VSP) Vision Service Plan
Employee Assistance Program	Insured	ComPsych
Voluntary Long Term Disability	Insured	Sunlife
Voluntary Short Term Disability	Insured	Sunlife
Group Term Life	Insured	(Mutual of Omaha) United of Omaha Life Insurance Company
Voluntary Term Life	Insured	Sunlife
Voluntary Dependent Term Life	Insured	Sunlife
Universal Life (Permanent Life)	Insured	Trustmark
AD&D	Insured	(Mutual of Omaha) United of Omaha Life Insurance Company
Voluntary AD&D	Insured	Sunlife

**AMENDMENT #2**

**to the**

**Prime, Inc. Employee Benefits Plan**

Section 7.1 of *Prime, Inc. Employee Benefits Plan* (“the Plan”) provides that the Employer may amend the Plan at any time. In accordance with the terms of those provisions, Appendix III of the Plan is hereby amended as reflected in this document.

preceding the commencement of his or her Break in Service, the Employer may similarly treated as a newly hired Employee for purposes of 4980H when again credited with an Hour of Service.

The Employer will apply the Rule of Parity unless it elects not do so by checking the following box:

The Employer elects to not apply the Rule of Parity.

**G. Effective Date:** This Appendix is effective:

With respect to determinations for Stability Periods beginning on or after January 1, 2015.

Such other date as reflected here: \_\_\_\_\_  
\_\_\_\_\_.

the last day of the payroll period that precedes the payroll period that includes the last day of the period designated above, or

- (ii) *Late Start, Late Stop.* The Standard Measurement Period will begin on the first day of the first payroll period that follows the payroll period that includes the first day of the period designated above, and end on the last day of the payroll period that includes the last day of the period designated above.

**Standard Administrative Period:**

The period of no more than 90 days that begins on \_\_\_\_\_ *[insert month and day]*,<sup>14</sup> and ends on \_\_\_\_\_ *[insert month and day]*.<sup>15</sup>

Where the Employer intends to implement the payroll period rule described above, the Standard Administrative Period is the period of no more than 90 days that begins the day following the last day of the Standard Measurement Period, and continues through the day prior to the first day of the Standard Stability Period.

**Standard Stability Period:**

The period beginning on \_\_\_\_\_ *[insert month and day]* and ending on \_\_\_\_\_ *[insert month and day]*.<sup>16</sup>

- F. Breaks in Service and Rule of Parity:** An Employee generally may be treated as a newly hired Employee for purposes of 4980H if he or she incurs a Break in Service (a period of time during which the Employee is credited with no Hours of Service) of at least 13 consecutive weeks (at least 26 weeks in the case of an Employer that is an educational institution) before again being credited with an Hour of Service.<sup>17</sup>

The Rule of Parity is similar, and provides that if an employee experiences a Break in Service of at least four but fewer than 13 consecutive weeks (26 consecutive weeks in the case of an Employer that is an educational institution) , and the Break in Service exceeds the number of weeks of the Employee’s period of employment with the Employer immediately

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<sup>14</sup> Insert the date that is the day following the last day of the Standard Measurement Period.

<sup>15</sup> Insert the date that is the day immediately preceding the beginning of the Standard Stability Period.

<sup>16</sup> The Standard Stability Period is normally the plan year. The Standard Stability Period must begin on the first day of a calendar month. It must be at least six calendar months in duration (or if greater, at least as long as the Standard Measurement Period) for Employees emerging from the Standard Measurement Period as Full-Time Employees. For Employees emerging as non-Full-Time Employees the Standard Stability Period may not be longer than the Standard Measurement Period. As a practical matter this means that in those typical cases where the Standard Measurement Period is at least six months, the Standard Stability Period will be the same duration as the Initial Measurement Period. As noted, most typically the Standard Measurement Period is 12 months long, and the Standard Stability Period is the 12-month plan year.

<sup>17</sup> There are special rules that apply where the Employee’s Break in Service is or includes unpaid FMLA, USERRA or jury duty leave. The Employer will administer this provision in accordance with those rules.

Where the Initial Measurement Period is less than 12 months and begins other than on the first day of a calendar month, such as on the employee's Start Date or the first day of payroll period, where these dates are not the first day of a calendar month:

- The Employer will determine the Initial Stability Period on an Employee-by-Employee basis, but the duration of the Initial Stability Period will be the same for all Employees unless the Employer applies different Initial Stability Periods to Employees in different groups of Employees as permitted by 4980H.<sup>10</sup>

**E. Standard Measurement, Administrative and Stability Periods.** If the Lookback Measurement Method is selected in B. above, the following Standard Measurement, Administrative and Stability Periods apply with respect to Ongoing Employees (Employees employed through an entire Standard Measurement Period) in the categories of Employees designated in A. above:

**Standard Measurement Period:**

For In-House Associates:

The period beginning on date of hire and ending on the first Saturday following the 30<sup>th</sup> day of active employment.<sup>11</sup>

For Company Drivers:

The period beginning on date of hire and ending on the 90<sup>th</sup> day of active employment.<sup>12</sup>

- Check this box if the Employer intends to implement the payroll period rule below.

*Payroll Period Rule.*<sup>13</sup> The Standard Measurement Period designated above may be adjusted consistent with the payroll period rule in 4980H, such that either:

- (i) *Early Start, Early Stop.* The Standard Measurement Period will begin on the first day of the payroll period that includes the first day of the period designated above, and end on

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*this means that in those typical cases where the Initial Measurement Period is at least six months, the Initial Stability Period will usually be the same duration as the Initial Measurement Period.*

However, because the Initial Stability Period may be up to one-month *longer* than the Initial Measurement Period, the Employer has some flexibility it might find helpful. If the Employer wants a 12-month Initial Stability Period, but needs a bit more than a one-month (or one-month and a partial month) Initial *Administrative* Period, it might use an 11-month Initial Measurement Period, followed by a *two*-month Initial Administrative Period, followed by the 12-month Initial Stability Period.

<sup>9</sup> See footnote 7 for rules regarding the length of the Initial Administrative Period.

<sup>10</sup> See footnote 1.

<sup>11</sup> The Standard Measurement Period must be at least three months, but no longer than 12 months. It need not be *calendar* months. Most employers use 12-month Standard Measurement Periods, and conclude them around the time open enrollment begins, but not more than 90 days prior to the beginning of the new plan year.

<sup>12</sup> The Standard Measurement Period must be at least three months, but no longer than 12 months. It need not be *calendar* months. Most employers use 12-month Standard Measurement Periods, and conclude them around the time open enrollment begins, but not more than 90 days prior to the beginning of the new plan year.

<sup>13</sup> This payroll period rule may apply only where hourly employees are paid weekly, biweekly, or semi-monthly.

**Initial Administrative Period:** The period that begins on the day following the last day of the Initial Measurement Period, and continues through the day prior to the first day of the Initial Stability Period.<sup>7</sup>

**Initial Stability Period:**

*Where the Initial Measurement Period is 12 months and begins on the first day of a calendar month:*

- The 12 consecutive calendar months starting on the first day of the calendar month beginning after the first anniversary of the date on which the Employee’s Initial Measurement Period began.

**Example:** Employee’s Start Date is February 17, 2015, and the 12-month Initial Measurement Period began March 1, 2015. The first anniversary of the date on which the Initial Measurement Period began is March 1, 2016. The Initial Stability Period begins April 1, 2016, the first day of the calendar month beginning after that anniversary. The Initial Stability Period runs from April 1, 2016 – March 31, 2017.

*Where the Initial Measurement Period is 12 months and begins other than on the first day of a calendar month, such as on the employee’s Start Date or the first day of payroll period, where these dates are not the first day of a calendar month:*

- The 12 consecutive calendar months starting on the first day of the second calendar month beginning after the first anniversary of the date on which the Employee’s Initial Measurement Period began.

**Example:** Employee’s Start Date is February 17, 2015, and the 12-month Initial Measurement Period began that day. The first anniversary of the date on which the Initial Measurement Period began is February 17, 2016. The Initial Stability Period begins April 1, 2016, the first day of the second calendar month beginning after that anniversary. The Initial Stability Period runs from April 1, 2016 – March 31, 2017.

*Where the Initial Measurement Period is less than 12 months and begins on the first day of a calendar month:*

- A period of <sup>8</sup> consecutive calendar months (up to 12 months, but not exceeding the length of the Initial Measurement period plus one month), beginning with the first day of the calendar month that begins after an Administrative Period permitted by 4980H.<sup>9</sup>

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<sup>7</sup> Note that the Initial Administrative Period (1) cannot exceed 90 days, (2) must include any period of time between the employee’s Start Date and the first day of the Initial Measurement Period (where that Measurement Period begins after the Start Date, such as the first day of the following month), and (3) together with the Initial Measurement Period, cannot extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee’s Start Date.

<sup>8</sup> The Initial Stability Period must begin on the first day of a calendar month. It must be at least six calendar months in duration (or if greater, at least as long as the Initial Measurement Period) for Employees emerging from the Initial Measurement Period as Full-Time Employees. For Employees emerging as non-Full-Time Employees the Initial Stability Period may not be more than one month longer than the Initial Measurement Period. *As a practical matter*

For purposes of determining Hours of Service for *non-hourly Employees* designated in A. above, the following equivalency applies:

- Actual Hours of Service from records of hours worked or hours for which payment is made
- Days worked (i.e., credited with 8 Hours of Service for each day with respect to which the Employee has at least one Hour of Service)
- Weeks worked (i.e., credited with 40 Hours of Service for each week with respect which the employee has at least one Hour of Service)
- Other, as described: \_\_\_\_\_ (must be reasonable and not understate an employee's Hours of Service)

**D. Initial Measurement, Administrative and Stability Periods.** *If the Lookback Measurement Method is selected in B. above, complete this section D.*

The following initial Measurement, Administrative and Stability Periods apply with respect to newly-hired Variable Hour, Part-Time or Seasonal Employees in the categories of Employees designated in A. above:<sup>4</sup>

**Initial Measurement Period:**

- Start Date.* The period beginning on the employee's Start Date (the date the Employee is first credited with an Hour of Service) and ending after [ ] consecutive months.<sup>5</sup>
- First of the Month.* The period beginning on the first day of the first calendar month following the Employee's Start Date, and ending after [ ] consecutive months.<sup>6</sup>
- Payroll Period Rule.* The period beginning on the first day of the first payroll period that begins *after* the Employee's Start Date and ending on the last day of the payroll period that *includes* the date, [ ] consecutive months<sup>6</sup> after the employee's Start Date, that but for application of this payroll period rule would otherwise be the last day of the employee's Initial Measurement Period. *This payroll period rule may apply only where hourly employees are paid weekly, biweekly, or semi-monthly.*<sup>6</sup>

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<sup>4</sup> The Employer may apply measurement, administrative and stability periods that differ in length or in starting or ending dates for different groups of Employees listed in footnote 1. *If the Employer will apply different periods to different groups, the Employer will need multiple Appendices (one for each such separate group), identifying the measurement, administrative and stability periods that will apply to each separate group.*

<sup>5</sup> The Initial Measurement Period must be at least three months, and no longer than 12 months.

<sup>6</sup> Here's an example of the payroll period rule. Employee's Start Date is March 4, 2015, and the first day of the payroll period that begins thereafter commences on March 16. The Employer uses a 12-month Initial Measurement Period. But for the payroll period rule, the Employee's Initial Measurement Period would run from March 4, 2015, through March 3, 2016. The Employer chooses to begin the Initial Measurement Period later, on the first day of the March 16, 2015 payroll period. The Initial Measurement Period must thus end later than it otherwise would; it ends on the last day of the payroll period that *includes* March 3, 2016...the date that would otherwise be the last day of the Employee's Initial Measurement Period.

## Appendix (Optional)

**A. Employees to Whom This Appendix Applies.** This Appendix applies for determining “Full-Time Employee” status, for purposes of 4980H, with respect to the following Employees:

- All Employees  
 The following employees: (check one or more)

Salaried Employees

- All salaried Employees  
 The following salaried Employees: \_\_\_\_\_<sup>1</sup>

Hourly Employees

- All hourly Employees  
 The following hourly Employees: \_\_\_\_\_<sup>1</sup>

Collectively bargaining employees

- All collectively bargained Employees  
 The following collectively bargained Employees: \_\_\_\_\_

- Other, as described: \_\_\_\_\_<sup>1</sup>

**B. Method for Determining Full-Time Employees.** The Employer elects to use the following method permitted by 4980H to determine Full-Time Employee status with respect to the employees identified in A. above (*choose one*):<sup>2</sup>

- Monthly Measurement Method<sup>3</sup>  
 Lookback Measurement Method

**C. How Hours of Service Are Counted for *Non-Hourly Employees*.** *If the Employees designated in A. above include non-hourly Employees, complete this section C.*

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<sup>1</sup> The rules permit differences among only the following five classifications: collectively bargained and noncollectively bargained employees, employees covered by different collective bargaining agreements, salaried and hourly employees, employees whose primary places of employment are in different states, and employees of different entities (i.e., different EINs) within a controlled group).

<sup>2</sup> The Employer should check only one box here, not both. The Employer may apply one method with respect to certain categories of Employees described in footnote 1, and another method for other groups described in that footnote. *If the Employer will apply one method to one group, and another method for another group, the Employer will need multiple Appendices (one for each such separate group), identifying the method that will apply to each separate group.*

<sup>3</sup> Few employers will want to utilize the Monthly Measurement Method. Note that pursuant to 4980H, under the Lookback Measurement Method newly hired employees who are not Variable Hour, Part-Time or Seasonal Employees will have their status as Full-Time Employees determined under the Monthly Measurement Method until they become Ongoing Employees (i.e., have been employed through an entire Standard Measurement Period), and thereafter their status as Full-Time Employees will be determined using the Lookback Measurement Method.

eligibility provisions of the Employer's group medical insurance program(s), and the Employer may construe and apply this Policy, or any portion of this Policy, in such a manner as to mitigate or avoid potential penalties under 4980H. Nothing in this Policy shall limit the Employer's ability to treat Employees more favorably than how they would be treated under the minimum requirements of 4980H.

## **7. Definitions**

Terms that appear as capitalized terms in this Policy and, as applicable, in any Appendix hereto, have the meanings ascribed to such terms under 4980H.

- Transition Employees from status as new Part-Time Employees, Variable Hour Employees or Seasonal Employees to “Ongoing Employees” after the Employees are employed through an entire Standard Measurement Period.
- Apply the rule of parity and/or 13-week (or as applicable, 26-week) Break in Service rule to an Employee’s Breaks in Service during a measurement period.
- Apply rules related to Special Unpaid Leave and, as applicable, Employment Break Periods.
- Continue an Employee’s status as a Full-Time Employee (or non-Full-Time Employee) for the period between the end of his or her Initial Stability Period and the first day of his or her first Standard Stability Period.
- Address changes in employment status during an Initial Measurement Period, or during a Stability Period.
- Treat an Employee as having terminated employment upon certain transfers to a position where substantially all of the compensation will constitute non-U.S. source income, consistent with the rules related to COBRA payments.
- Administer processes related to nonpayment, late payment or partial payment of premiums.
- Continue eligibility of an otherwise eligible biological or adopted child of an Employee who is an eligible Full-Time Employee to the end of the month in which the child attains age 26, where eligibility may otherwise have terminated, but only to the extent necessary to avoid potential penalties under 4980H.

#### **4. Determinations of Minimum Value and Affordability**

Where the Employer intends to supply coverage satisfying 4980H(b) of the Code (i.e., Minimum Value and Affordable coverage), it may determine the actuarial value of a health coverage offering in any manner permissible under 4980H.

For purposes of determining the affordability of such coverage offering, with respect to Full-Time Employees, the Employer may utilize one or more “affordability safe harbors” as provided under, and to the extent permitted by, 4980H, and shall otherwise comply with 4980H when including wellness incentives and/or the value of reimbursement programs (such as a health reimbursement arrangement) in determinations of minimum value and affordability.

#### **5. Offers of Coverage**

To the extent the Employer intends to treat an Employee as eligible for at least Minimum Essential Coverage on account of the Employee’s status as a Full-Time Employee under 4980H, the Employer intends to make to such an Employee an “offer of coverage,” and where appropriate renew an offer of coverage to the Employee (e.g., upon a Full-Time Employee’s return from a Break in Service under circumstances where the Employee may not be treated as a newly hired employee under 4980H) at the time(s), and in a manner, consistent with 4980H.

#### **6. Modification and Interpretation**

This Policy may be modified or amended at any time in the sole discretion of the Employer. The provisions of this Policy reflect merely general operating rules for the administration of the

## **2. Tracking Hours of Service**

The Employer must determine an hourly Employee's Hours of Service on the basis of actual hours worked and hours for which payment is made or due. For non-hourly Employees, the Employer may determine the Employee's Hours of Service on the basis of either: (i) actual hours worked and hours for which payment is due, or (ii) one or more equivalencies for determining Hours of Service, as permitted by 4980H, provided no such equivalency has the effect, in practice, of understating Employees' Hours of Service. To the extent required by 4980H, Employees will also be credited with Hours of Service for periods of time for which no actual service for the Employer is performed but for which payment is due (e.g., paid time off, vacation, and sick leave).

## **3. Application of Monthly or Look-Back Measurement Methods; Determination of Measurement, Administrative and Stability Periods; Administration of Same**

For purposes of determining an Employee's status as a Full-Time Employee for purposes of 4980H, the Employer may track the Employee's Hours of Service using the Monthly Measurement Method or the Look-Back Measurement Method, as described in 4980H. The Employer may communicate to Employees regarding which method the Employer chooses to use (e.g., the communication may simply provide that Employees' Hours of Service are tracked monthly, or over a look-back measurement period, or monthly and then—when the Employee becomes an Ongoing Employee, over a look-back measurement period) and, where the Employer utilizes the Look-Back Measurement Method, communicate such look-back periods to Employees from time to time. To the extent permitted by 4980H, the Employer may apply one method with respect to certain Employees, and another method with respect to other Employees, and may change the method from time to time, at the Employer's discretion. The Employer may designate these methods and the categories of Employees to whom they apply in one or more Appendices attached to this Policy.

Where the Employer utilizes the Look-Back Measurement Method, it may (consistent with 4980H) designate one or more Initial Measurement Periods, Initial Administrative Periods and Initial Stability Periods, and may designate one or more Standard Measurement Periods, Standard Administrative Periods and Standard Stability Periods. To the extent permitted by 4980H, the Employer may apply different measurement, administrative and stability periods with respect to different Employees, and may change the measurement, administrative and stability periods from time to time, at the Employer's discretion. The Employer may designate these periods and the categories of Employees to whom they apply in one or more Appendices attached to this Policy.

The Employer will administer application of the Monthly Measurement Method and/or, as applicable, the Look-Back Measurement Method, in accordance with 4980H. Thus, for example, the Employer may (or will, where such administration is required) do the following as provided by 4980H:

- Commence and terminate measurement periods slightly before, or after, the designated measurement period commencement and termination dates so as to incorporate full payroll periods into the measurement periods.

**Policy Document for Full-Time Employee Determinations  
Under the Patient Protection and Affordable Care Act  
NEW PRIME, INC.**

NEW PRIME, INC. (“the Employer”) sponsors and maintains, or participates in, one or more group medical insurance programs for the benefit of eligible Employees and their eligible dependents. One or more of such programs may condition eligibility of the Employee upon the Employee’s status as a “Full-Time Employee” under the Patient Protection and Affordable Care Act of 2010, as amended (“the ACA”) and Section 4980H of the Internal Revenue Code (“the Code”), and regulations and other guidance issued thereunder (collectively “4980H”).

This Policy is adopted by the Employer to establish general standards and procedures for identifying Full-Time Employees pursuant to 4980H, either for purposes of qualifying the Employee as eligible for an offer of medical insurance coverage, for reporting and disclosure purposes, and/or for other purposes relevant to 4980H. This Policy is also adopted to reflect the Employer’s intent, and establish practices and procedures consistent with such intent, to comply generally with certain requirements of 4980H with respect to certain Employees identified by the Employer in relevant documents, including benefit plan documents and/or one or more appendices attached to this Policy.

This Policy is first effective, with respect to determinations relating to reporting under Sections 6055 and 6056 of the Code, as of January 1, 2015 or, if later, the first day with respect to which the Employer is an Applicable Large Employer or Applicable Large Employer Member subject to the reporting obligations under those sections. This Policy is first effective with respect to other determinations related to the Employer’s effort to comply with 4980H, as applicable, as of the date the health insurance coverage offer provisions of 4980H apply to the Employer. Some of these determinations might involve calculations based on Hours of Service credited to an Employee for periods prior to the effective date of this Policy. This Policy may be amended from time to time, and the effective date of any such amendment will be specified therein.

**1. Designation of Employees**

The Employer may designate newly hired Employees (and Employees the Employer may treat as newly-hired Employees under 4980H, such as Employees again accruing Hours of Service following certain Breaks in Service) as either:

- Full-Time Employees,
- Part-Time Employees,
- Variable Hour Employees, or
- Seasonal Employees,

as of their respective Start Dates (or may apply other designations effectively accomplishing the same distinctions), applying factors specified in 4980H. The Employer may re-designate or re-classify an Employee as appropriate based on re-assignment of duties, change in anticipated average Hours of Service, and/or on the basis of actual average Hours of Service over specific measurement periods.

*Note: Some clients may have their plan amendments formally approved by their board of directors or an authorized committee, such as a benefits committee. Below is a sample resolution that may be used for this purpose.*

**SAMPLE BOARD OR COMMITTEE RESOLUTION**

**ADOPTING PLAN AMENDMENT**

WHEREAS, \_\_\_\_\_ (the “Employer”) previously adopted a single, comprehensive health and welfare plan document (the “Wrap Plan”) for the benefit of eligible employees;

WHEREAS, the Employer now desires to amend the Wrap Plan to reflect recent regulatory guidance relating to Health Care Reform and to make certain other changes;

NOW, THEREFORE, BE IT RESOLVED, that the Wrap Plan amendment, in the form attached hereto, be and hereby is adopted, ratified, and approved effective as of the date(s) set forth therein; and

RESOLVED FURTHER, that any and all actions taken by or on behalf of the officers of the Company prior to the adoption of these resolutions which are within the authority conferred hereby are authorized, adopted, ratified, confirmed and approved in all respects.

SIGNATURE PAGE

IN WITNESS WHEREOF, the Employer hereby adopts this Amendment effective as of the date(s) set forth herein.

NEW PRIME, INC.

By Olivia Guthrie  
Title HR Director  
Date 12/29/15

	<p>for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 1<sup>st</sup> of the month following 90 days of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
AD&D	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 90<sup>th</sup> day of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
Voluntary AD&D	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 1<sup>st</sup> of the month following 90 days of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
Accident	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 1<sup>st</sup> of the month following 90 days of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
Critical Illness (Includes Cancer)	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 1<sup>st</sup> of the month following 90 days of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>

	<p>Effective Date of Employee Coverage: Employee coverage begins on the 1<sup>st</sup> of the month following 90 days of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
Voluntary Short Term Disability	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 1<sup>st</sup> of the month following 90 days of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
Group Term Life	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 90<sup>th</sup> day of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
Voluntary Term Life	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 1<sup>st</sup> of the month following 90 days of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
Voluntary Dependent Term Life	<p>Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents:</p> <ul style="list-style-type: none"> <li>• Spouse, including / but not a common law spouse;</li> <li>• Children of the Employee, including biological children, step-children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26.</li> </ul> <p>Effective Date of Dependent Coverage: Dependents are eligible for coverage on the later of (i) the date the Employee is eligible, or (ii) the date the person becomes a Dependent.</p> <p>Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the date the Employee's coverage terminates or (ii) the date the person ceases to be a Dependent (iii) for dependent children, the end of the calendar month for which they turn age 26.</p>
Universal Life (Permanent Life)	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible</p>

	<p>coverage terminates on the end of coverage period for which the premium has been paid.</p> <p>Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents:</p> <ul style="list-style-type: none"> <li>• Spouse, including / but not a common law spouse;</li> <li>• Children of the Employee, including biological children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26, except there is no limiting age for children who are dependent on the Employee as the result of a physical or mental handicap.</li> </ul> <p>Effective Date of Dependent Coverage: Dependents are eligible for coverage on the later of (i) the date the Employee is eligible, or (ii) the date the person becomes a Dependent.</p> <p>Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the date the Employee's coverage terminates or (ii) the end of the coverage period for which the premium has been paid.</p>
Vision	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 90<sup>th</sup> day of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the first day of the month following termination of employment.</p> <p>Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents:</p> <ul style="list-style-type: none"> <li>• Spouse, including / but not a common law spouse;</li> <li>• Children of the Employee, including biological children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26, except there is no limiting age for children who are dependent on the Employee as the result of a physical or mental handicap.</li> </ul> <p>Effective Date of Dependent Coverage: Dependents are eligible for coverage on the later of (i) the date the Employee is eligible, or (ii) the date the person becomes a Dependent.</p> <p>Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the date the Employee's coverage terminates or (ii) the first day of the month after the person ceases to be a Dependent.</p>
Voluntary Long Term Disability	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p>

	Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.
Critical Illness (Includes Cancer)	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 1<sup>st</sup> of the month following 30 days of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>

### ELIGIBILITY MATRIX FOR COMPANY DRIVERS

<b>Component Program</b>	<b>Eligibility</b>
Medical	<p>Eligible Employees: All W-2 Associates scheduled to work at least 30 hours per week.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 90<sup>th</sup> day of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p> <p>Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents:</p> <ul style="list-style-type: none"> <li>• Spouse, including / but not a common law spouse;</li> <li>• Children of the Employee, including biological children, step-children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26.</li> </ul> <p>Effective Date of Dependent Coverage: Dependents are eligible for coverage on the later of (i) the date the Employee is eligible, or (ii) the date the person becomes a Dependent.</p> <p>Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the date the Employee's coverage terminates or (ii) the date the person ceases to be a Dependent (iii) for dependent children, the end of the calendar month for which they turn age 26.</p>
Dental	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 90<sup>th</sup> day of active employment.</p> <p>Termination Date of Employee Coverage: Employee</p>

Voluntary Dependent Term Life	<p>Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents:</p> <ul style="list-style-type: none"> <li>• Spouse as recognized under the laws of the state where Employee resides;</li> <li>• Children of the Employee, including biological children, step-children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26.</li> </ul> <p>Effective Date of Dependent Coverage: Dependents are eligible for coverage on the later of (i) the date the Employee is eligible, or (ii) the date the person becomes a Dependent.</p> <p>Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the date the Employee's coverage terminates or (ii) the date the person ceases to be a Dependent (iii) for dependent children, the end of the calendar month for which they turn age 26.</p>
Universal Life (Permanent Life)	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 1<sup>st</sup> of the month following 30 days of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
AD&D	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the Saturday following the 30<sup>th</sup> day of active employment..</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
Voluntary AD&D	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 1<sup>st</sup> of the month following 30 days of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
Accident	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 1<sup>st</sup> of the month following 30 days of active employment.</p>

	<ul style="list-style-type: none"> <li>• Spouse as recognized under the laws of the state where Employee resides;</li> <li>• Children of the Employee, including biological children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26, except there is no limiting age for unmarried children who are dependent on the Employee as the result of a physical or mental handicap.</li> </ul> <p>Effective Date of Dependent Coverage: Same as medical.</p> <p>Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the first day of the month after Employee's coverage terminates or (ii) the first day of the month after the person ceases to be a Dependent.</p>
Voluntary Long Term Disability	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the Saturday following the 30<sup>th</sup> day of active employment..</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
Voluntary Short Term Disability	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the Saturday following the 30<sup>th</sup> day of active employment..</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
Group Term Life	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the Saturday following the 30<sup>th</sup> day of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>
Voluntary Term Life	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 1<sup>st</sup> of the month following 30 days of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p>

	<ul style="list-style-type: none"> <li>Children of the Employee, including biological children, step-children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26.</li> </ul> <p>Effective Date of Dependent Coverage: Dependents are eligible for coverage on the later of (i) the date the Employee is eligible, or (ii) the date the person becomes a Dependent.</p> <p>Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the date the Employee's coverage terminates or (ii) the date the person ceases to be a Dependent (iii) for dependent children, the end of the calendar month for which they turn age 26.</p>
Dental	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the Saturday following the 30<sup>th</sup> day of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the end of coverage period for which the premium has been paid.</p> <p>Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents:</p> <ul style="list-style-type: none"> <li>Spouse as recognized under the laws of the state where Employee resides;</li> <li>Children of the Employee, including biological children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26, except there is no limiting age for children who are dependent on the Employee as the result of a physical or mental handicap.</li> </ul> <p>Effective Date of Dependent Coverage: Same as medical.</p> <p>Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the date the Employee's coverage terminates or (ii) the end of the coverage period for which the premium has been paid.</p>
Vision	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the Saturday following the 30<sup>th</sup> day of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the first day of the month following termination of employment.</p> <p>Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents:</p>

This Plan is not in place of and does not affect any requirement for coverage by workers' compensation insurance or program; provided, however, the Plan Administrator in its sole discretion reserves the right to coordinate the receipt of workers' compensation benefits with any self-insured benefits available under this Plan and may determine that such workers' compensation benefits shall offset or otherwise reduce the benefits available under this Plan

7. Section 8.16 of the Plan is amended by deleting the entire paragraph and inserting the following new paragraph in its place. This change merely conforms the Plan document to existing Plan intent, practice and procedure and therefore requires no effective date:

8.16 Time for Bringing Actions Against the Plan

Notwithstanding any provision in this Plan document or the terms of a Component Document to the contrary, no legal action may be brought to recover from or with respect to this Plan (i) prior to the date the claimant has exhausted all administrative remedies under this Plan and applicable Component Documents, or (ii) after the date that is eighteen (18) months following the date the claimant has received a final decision on appeal with respect to such claim.

8. A new Section 8.22 is added to read as follows. This change merely conforms the Plan document to existing Plan intent, practice and procedure and therefore requires no effective date:

8.22 Indemnity of Employees

To the extent any Employee or committee of Employees has been appointed to serve as the Plan Administrator, the Employer shall indemnify and hold each such individual harmless from any and all liabilities or expenses of any kind incurred by such individual in carrying out their administrative responsibilities under the Plan, except to the extent such liabilities or expenses result from the gross negligence or willful misconduct of the individual.

9.<sup>2</sup> The Eligibility Appendix/Matrix of the Plan is restated in its entirety in the form attached hereto. This change is effective as of *January 1, 2015*.

**ELIGIBILITY MATRIX FOR IN-HOUSE ASSOCIATES**

<b>Component Program</b>	<b>Eligibility</b>
Medical	<p>Eligible Employees: All W-2 Associates scheduled to work at least 30 hours per week.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the Saturday following the 30<sup>th</sup> day of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p> <p>Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents:</p> <ul style="list-style-type: none"> <li>• Spouse as recognized under the laws of the state where Employee resides;</li> </ul>

Where coverage is terminated pursuant to the preceding paragraph, it may be terminated prospectively. Coverage may also be terminated retroactively to the date of (as applicable) the action giving rise to the termination or, where termination is due to ineligibility or failure to timely pay premium, to the date of the person's enrollment or, if later, the date the person became ineligible; provided, however, that with respect to Component Programs subject to the PPACA, coverage shall be terminated retroactively only in the event of fraud or material misrepresentation (both of which are hereby expressly prohibited by this Plan), or to the extent otherwise permitted by the PPACA or guidance issued thereunder (including but not limited to failure to timely pay required premiums or contributions), and upon appropriate notice to the person as may be required under the PPACA Act or regulations.

4. Section 5.11 of the Plan is amended by deleting paragraph (a) in its entirety so that Section 5.11 read in its entirety as follows. This change merely conforms the Plan document to existing Plan intent, practice and procedure and therefore requires no effective date:

#### 5.11 Nondiscrimination Rules

*[DELETE: (a) The Plan Administrator will not take any action or direct any action with respect to any of the benefits provided hereunder that would be impermissibly discriminatory in favor of Employees who are officers or highly compensated Employees of the Employer or an Affiliated Employer, or that would result in benefiting one Covered Person or group of Covered Persons at the expense of another, or in the application of different rules to substantially similar sets of facts.*

*(b)]*

The Plan will comply with all applicable nondiscrimination rules under the Code and any other applicable law. Should the Plan be subject to nondiscrimination testing under the Code or any other applicable law, the Plan Administrator may make any decisions or elections, whether voluntary or required by law, necessary to facilitate such testing. Any elections required to be in writing (e.g., the designation of separate testing plans, where disaggregation or aggregation of Component Programs or portions of Component Programs is permitted or required) will be stated from time to time in Appendices to the Plan, to the extent required by applicable law.

5. Section 8.2 of the Plan is amended by adding the following new sentence to the end of such Section. This change merely conforms the Plan document to existing Plan intent, practice and procedure and therefore requires no effective date:

#### 8.2 Participation by Affiliated Employers

The Employer may permit any of its Affiliated Employers or Participating Non-Controlled Group Employers to participate in one or more benefits under the Plan.  
*[ADD: An Affiliated Employer or Participating Non-Controlled Group Employer will be deemed to have adopted the Plan and become an "Employer" hereunder by making contributions under the Plan.]*

6. Section 8.14 of the Plan is amended by deleting the entire paragraph and inserting the following new paragraph in its place. This change merely conforms the Plan document to existing Plan intent, practice and procedure and therefore requires no effective date:

#### 8.14 Workers' Compensation

## AMENDMENT

to the

### Prime, Inc. Employee Benefits Plan

Section 7.1 of *Prime, Inc. Employee Benefits Plan* (“the Plan”) provides that the Employer may amend the Plan at any time. In accordance with the terms of those provisions, the Plan is hereby amended as reflected in this document.

This Amendment modifies the Plan in certain respects to conform to, or to permit the Employer to conform to, the requirements of the Patient Protection and Affordable Care Act (“PPACA”), specifically the employer “shared responsibility” provisions codified in section 4980H of the Internal Revenue Code and regulations and other guidance issued thereunder (collectively, “section 4980H”); limitations on waiting periods described in the PPACA, and regulations and other guidance issued thereunder; and other applicable provisions of the PPACA.

This Amendment supersedes any conflicting provision of the Plan where the conflicting provision predates the effective date of any change made by this Amendment. To the extent this Amendment is adopted after the effective date of any change set forth below, the Amendment conforms the Plan document to Plan intent, practice and procedure as of that effective date.

1.<sup>1</sup> The definition of “Employee” under Article I of the Plan is amended by adding the following paragraph to the end thereof. This change is effective as of *January 1, 2015*.

Notwithstanding the foregoing, if, for any period of time, an individual has not, on the Employer’s books and records, been treated as a common law employee of the Employer (or “full-time” common law employee, as defined under the Employer’s *Policy Document for Full-Time Employee Determinations Under the PPACA* (“PPACA Policy”), where eligibility for coverage under a Component Program depends on full-time status), and a court or government agency subsequently makes a determination that the individual was in fact a common law employee during that period of time, such determination shall not entitle the individual to any retroactive rights under the Plan unless this Plan is amended to supply such retroactive rights, and the individual’s prospective rights under the Plan shall be determined solely in accordance with the terms of the Plan.

2. Article I is amended by inserting the following new definition in alphabetical order:

#### PPACA

“PPACA” means the Patient Protection and Affordable Care Act of 2010, as amended, and including all regulations and other guidance under that Act.

3. Section 2.3 of the Plan is amended by deleting the last paragraph thereunder and by inserting the following new paragraph in its place. This change merely conforms the Plan document to existing Plan intent, practice and procedure, as permitted by regulations and/or other guidance under the PPACA, and therefore requires no effective date:

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<sup>1</sup> Paragraph numbers in the Amendment should be numbered consecutively, starting with “1.”

AD&D	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>
Voluntary AD&D	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>
Accident	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>
Worksite Illness (includes Cancer)	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>

*Please note that coverage begins only upon successful enrollment within the time period specified by the Component Documents. Coverage may also terminate due to nonpayment of premiums, elimination of coverage by the Employer, disenrollment by the Employee, or any other reason permitted under the terms of the applicable Component Documents.*

*Notwithstanding any other provision of this document to the contrary, to the extent an applicable state law imposes upon this Plan or any Component Document of this Plan a more generous eligibility criteria than that reflected here, such other eligibility criteria will apply to the extent, and only to the extent, required by such applicable law.*

Voluntary Long Term Disability	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>
Voluntary Short Term Disability	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>
Group Term Life	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>
Voluntary Term Life	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>
Voluntary Dependent Term Life	<p>Eligible Employees: Same as medical.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>
Universal Life (Permanent Life)	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>

Dental	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the end of coverage period for which the premium has been paid.</p> <p>Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents:</p> <ul style="list-style-type: none"> <li>• Spouse, including / but not a common law spouse;</li> <li>• Children of the Employee, including biological children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26, except there is no limiting age for children who are dependent on the Employee as the result of a physical or mental handicap.</li> </ul> <p>Effective Date of Dependent Coverage: Same as medical.</p> <p>Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the date the Employee's coverage terminates or (ii) the end of the coverage period for which the premium has been paid.</p>
Vision	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the first day of the month following termination of employment.</p> <p>Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents:</p> <ul style="list-style-type: none"> <li>• Spouse, including / but not a common law spouse;</li> <li>• Children of the Employee, including biological children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26, except there is no limiting age for children who are dependent on the Employee as the result of a physical or mental handicap.</li> </ul> <p>Effective Date of Dependent Coverage: Same as medical.</p> <p>Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the date the Employee's coverage terminates or (ii) the first day of the month after the person ceases to be a Dependent.</p>

## APPENDIX IV

### ELIGIBILITY MATRIX FOR COMPANY DRIVERS

*(Updated effective January 1, 2014)*

*Important Note: This Matrix is merely a summary of the eligibility rules under the various Component Programs. More complete information is available from the Component Documents themselves, and from the Plan Administrator.*

*This Matrix applies solely to Employees classified by the Employer as Company Drivers Employees. Please contact the Plan Administrator for the correct Matrix if this is not your employment classification or if you are unsure of your classification.*

<b>Component Program(s)</b>	<b>Eligibility</b>
Medical	<p>Eligible Employees: All W-2 Associates scheduled to work at least 30 hours per week.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the 90<sup>th</sup> day of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p> <p>Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents:</p> <ul style="list-style-type: none"><li>• Spouse, including / but not a common law spouse;</li><li>• Children of the Employee, including biological children, step-children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26.</li></ul> <p>Effective Date of Dependent Coverage: Dependents are eligible for coverage on the later of (i) the date the Employee is eligible, or (ii) the date the person becomes a Dependent.</p> <p>Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the date the Employee's coverage terminates or (ii) the date the person ceases to be a Dependent (iii) for dependent children, the end of the calendar month for which they turn age 26.</p>

Critical Illness (includes Cancer)	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>
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*Please note that coverage begins only upon successful enrollment within the time period specified by the Component Documents. Coverage may also terminate due to nonpayment of premiums, elimination of coverage by the Employer, disenrollment by the Employee, or any other reason permitted under the terms of the applicable Component Documents.*

*Notwithstanding any other provision of this document to the contrary, to the extent an applicable state law imposes upon this Plan or any Component Document of this Plan a more generous eligibility criteria than that reflected here, such other eligibility criteria will apply to the extent, and only to the extent, required by such applicable law.*

Voluntary Term Life	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>
Voluntary Dependent Term Life	<p>Eligible Dependents: Same as medical.</p> <p>Effective Date of Dependent Coverage: Same as medical.</p> <p>Termination Date of Dependent Coverage: Same as medical.</p>
Universal Life (Permanent Life)	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>
AD&D	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>
Voluntary AD&D	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>
Accident	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>

Vision	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the first day of the month following termination of employment.</p> <p>Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents:</p> <ul style="list-style-type: none"> <li>• Spouse as recognized under the laws of the state where Employee resides;</li> <li>• Children of the Employee, including biological children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26, except there is no limiting age for unmarried children who are dependent on the Employee as the result of a physical or mental handicap.</li> </ul> <p>Effective Date of Dependent Coverage: Same as medical.</p> <p>Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the first day of the month after Employee's coverage terminates or (ii) the first day of the month after the person ceases to be a Dependent.</p>
Voluntary Long Term Disability	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>
Voluntary Short Term Disability	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>
Group Term Life	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Same as medical.</p>

Dental	<p>Eligible Employees: All full-time Employees regularly scheduled to work at least 30 hours per week are eligible for coverage.</p> <p>Effective Date of Employee Coverage: Same as medical.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the end of coverage period for which the premium has been paid.</p> <p>Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents:</p> <ul style="list-style-type: none"> <li>• Spouse as recognized under the laws of the state where Employee resides;</li> <li>• Children of the Employee, including biological children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26, except there is no limiting age for children who are dependent on the Employee as the result of a physical or mental handicap.</li> </ul> <p>Effective Date of Dependent Coverage: Same as medical.</p> <p>Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the date the Employee's coverage terminates or (ii) the end of the coverage period for which the premium has been paid.</p>
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## APPENDIX IV

### ELIGIBILITY MATRIX FOR IN-HOUSE ASSOCIATES

*(Updated effective January 1, 2014)*

*Important Note: This Matrix is merely a summary of the eligibility rules under the various Component Programs. More complete information is available from the Component Documents themselves, and from the Plan Administrator.*

*This Matrix applies solely to Employees classified by the Employer as In-House Associates Employees. Please contact the Plan Administrator for the correct Matrix if this is not your employment classification or if you are unsure of your classification.*

<b>Component Program(s)</b>	<b>Eligibility</b>
Medical	<p>Eligible Employees: All W-2 Associates scheduled to work at least 30 hours per week.</p> <p>Effective Date of Employee Coverage: Employee coverage begins on the Saturday following the 30<sup>th</sup> day of active employment.</p> <p>Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.</p> <p>Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents:</p> <ul style="list-style-type: none"><li>• Spouse as recognized under the laws of the state where Employee resides;</li><li>• Children of the Employee, including biological children, step-children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26.</li></ul> <p>Effective Date of Dependent Coverage: Dependents are eligible for coverage on the later of (i) the date the Employee is eligible, or (ii) the date the person becomes a Dependent.</p> <p>Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the date the Employee's coverage terminates or (ii) the date the person ceases to be a Dependent (iii) for dependent children, the end of the calendar month for which they turn age 26.</p>

(includes Cancer)		
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### APPENDIX III

#### COMPONENT DOCUMENTS

*(Updated effective January 1, 2014)*

The terms, conditions and limitations of the benefits described in Article III of the Plan are contained in the Component Documents listed from time to time in this Appendix III, which are incorporated herein by reference.

<b>Component Program</b>	<b>Insured or Self-Insured</b>	<b>Insurance Carrier or Administrator</b>
Medical (includes HSA/HDHP option)	Insured	(Anthem) Healthy Alliance Life Insurance Company
Dental	Insured	Ameritas Life Insurance Corporation
Vision	Insured	(VSP) Vision Service Plan
Voluntary Long Term Disability	Insured	Assurant
Voluntary Short Term Disability	Insured	Assurant
Group Term Life	Insured	(Mutual of Omaha) United of Omaha Life Insurance Company
Voluntary Term Life	Insured	Assurant
Voluntary Dependent Term Life	Insured	Assurant
Universal Life (Permanent Life)	Insured	Trustmark
AD&D	Insured	(Mutual of Omaha) United of Omaha Life Insurance Company
Voluntary AD&D	Insured	Assurant
Accident	Insured	Trustmark
Worksite Critical Illness	Insured	Trustmark

**APPENDIX II**

**LIST OF AFFILIATED EMPLOYERS AND PARTICIPATING NON-CONTROLLED  
GROUP EMPLOYERS**

*(Updated effective January 1, 2014)*

Affiliated Employers

None

Participating Non-Controlled Group Employers

None

<p>Type of Administration:</p>	<p>Administered according to the Component Documents.</p> <p>Some benefits under the Plan are insured by one or more insurance companies. Appendix III describes the various benefits, whether they are insured or self-insured, and the identity of the insurance companies and/or third-party administrators.</p> <p>With respect to benefits under the Plan which are self-insured, those benefits may be administered by a third-party administrator, including an insurance company. In those cases where an insurance company has been hired to administer a self-insured plan, the insurance company does not insure or guarantee the benefits that it administers; see Appendix III for the identity of the third-party administrator(s).</p> <p>The Employer may maintain a stop-loss or reinsurance policy to protect the Employer against catastrophic loss under the comprehensive medical benefit program offered under this Plan. However, the stop-loss insurance merely reimburses the Employer for benefits it funds under the program, and is not to be construed as “insuring” the comprehensive medical benefits under the program.</p>
<p>Agent for Legal Process:</p>	<p>Service of legal process may be made upon the Plan Administrator.</p>

**APPENDIX I**

**PLAN DESCRIPTION**

Plan Name:	Prime, Inc. Employee Benefit Plan
Plan Number:	501
Type of Plan:	Welfare benefit plan
Plan Year:	12-month period beginning January 1 and ending December 31
Plan Sponsor:	New Prime, Inc. 2740 N. Mayfair Springfield, MO 65803 (417) 866-0001
Plan Sponsor Tax Identification Number:	43-1396933
Participating Affiliates and Participating Non-Controlled Group Employers:	See Appendix II
Plan Administrator and Named Fiduciary:	New Prime, Inc. 2740 N. Mayfair Springfield, MO 65803 (417) 866-0001
Claims Administrator:	Unless otherwise described in the Component Document, the claims administrator is the insurer or third party administrator identified in Appendix III
Sources of Contributions:	Employee contributions and Employer contributions.
Funding Medium:	Contributions under the Plan may consist of both Employer contributions and Employee contributions. Employee contributions for coverage are paid through payroll deduction.

SIGNATURE PAGE

IN WITNESS WHEREOF, the Employer has caused this Plan to be adopted effective as of the date(s) set forth herein.

NEW PRIME, INC.

By: Olivia Guthrie

Name: Olivia Guthrie

Title: HR Director

Date: 12/30/14

certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

months (18 months for late enrollees) after your enrollment date in your coverage.

(c) Prudent Actions by Plan Fiduciaries:

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

(d) Enforce Your Rights:

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

(e) Assistance with Your Questions:

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain

## ARTICLE XII

### STATEMENT OF ERISA RIGHTS

#### 12.1 Covered Persons' Rights

As an Eligible Employee covered under the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all covered Eligible Employees will be entitled to:

- (a) Receive Information About Your Plan and Benefits:
  - (1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
  - (2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
  - (3) Receive a summary of the Plan's annual financial report. The Plan Administrator is normally required by law to furnish each participant with a copy of this summary annual report.
- (b) Continue Group Health Plan Coverage:
  - (1) Continue health care coverage for yourself, covered spouse or other Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your covered Dependents may have to pay for such coverage. Review this document and the Component Documents for the rules governing your COBRA continuation coverage rights.
  - (2) Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12

Payment for the period from the date coverage would otherwise terminate through the 45th day after COBRA Continuation Coverage is elected must be made by that 45th day (for example, if a person elects COBRA Continuation Coverage on the 30th day of the 60-day election period, he must make his first payment by the 75th day after he elected COBRA Continuation Coverage, and the payment must be for the period of COBRA Continuation Coverage from the date he would otherwise lose coverage to that 75th day). Thereafter, payments must be made within thirty (30) days after the monthly premium due date to be considered timely. The Plan will terminate coverage as of the qualifying event, but will reinstate it retroactively to the date of the qualifying event if a timely election for COBRA Continuation Coverage, and timely initial payment, are made.

The monthly cost of COBRA Continuation Coverage will be set for 12-month periods, and will not exceed 102% of the cost of coverage under the Plan for similarly situated Covered Persons. However, if a person qualifies for periods of extended coverage due to a disability (whether his or another Qualified Beneficiary's), the monthly COBRA premium during the period of extended coverage may be 150% of the cost of coverage under the Plan for similarly situated Covered Persons, depending on whether the disabled person continued coverage during the extended coverage period.

Please note that the terms of the Component Documents might set forth slightly different procedures for applying and paying for COBRA Continuation Coverage, or providing notice of certain qualifying events, or for other rights and obligations regarding COBRA Continuation Coverage. In that case the terms of the Component Document will control over this Article XI, to the extent the terms of the Component Document are consistent with applicable law.

#### 11.12 Questions and More Information

A Covered Person may contact the Plan Administrator or COBRA administrator if he or she has any questions concerning COBRA continuation rights. Covered Person may also obtain information about their rights under ERISA, including COBRA, the Health Insurance Portability or Accountability Act (HIPAA), and other laws affecting group health plans, by contacting the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

Each Covered Person must keep the Plan Administrator informed of any changes in the addresses of family members. A copy of any notices sent to the Plan Administrator should be retained by the Covered Person.

- (e) The person becomes covered - after the date he elects Continuation Coverage - under another group health plan (because of employment or otherwise) that contains an exclusion or limitation with respect to a pre-existing condition which is nullified, waived or does not apply because of the Health Insurance Portability and Accountability Act (HIPAA) rules; or
- (f) The Plan is terminated and the Employer maintains no group health plan for any of its active Employees.

#### 11.9 Notification Of A Qualifying Event

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of the Employee's employment or reduction of hours of employment, his death, the employer's commencement of a proceeding in bankruptcy with respect to a retiree (if applicable), or his enrollment in Medicare (Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events (of course, where the Plan Administrator is the Employer, there's no need for the Employer to notify itself of these events).

A COBRA Qualified Beneficiary must notify the Plan Administrator within 60 days of a divorce or legal separation, of a child ceasing to meet the Plan's definition of "Dependent", or of the Social Security Administration's determination of disability. In addition, if the person is a disabled individual who obtained 29 months of COBRA Continuation Coverage, he must notify the Plan Administrator of any determination by the Social Security Administration that he is no longer disabled. Notification to the Plan Administrator must be made within 30 days of the date such determination is made.

***Notice for the qualifying events described above must be sent, in writing (describing the qualifying event and the date it occurred) to the Plan Administrator or designated COBRA administrator.***

#### 11.10 Benefits That May Continue

If a COBRA Qualified Beneficiary elects COBRA Continuation Coverage, the coverage will be identical to the health coverage then being provided under the Plan to Eligible Employees or, if in the case of a Dependent, to covered Dependents of Eligible Employees. COBRA Qualified Beneficiaries do not have to prove insurability to choose continuation coverage, but are required to pay for it.

#### 11.11 Application And Payment Procedures

After a COBRA qualifying event (and the provision of any notice required by COBRA Qualified Beneficiary, as described in Section 11.9), the Plan Administrator will send or cause to be sent a more detailed notice and an application for continued coverage. To continue coverage under COBRA, a COBRA Qualified Beneficiary must complete and return the application to the Plan Administrator or its designee within 60 days from the later of the date the application is sent or the date coverage would otherwise terminate.

## 11.6 Multiple Qualifying Events

If a Dependent is eligible to choose and chooses to continue coverage under these provisions after an Employee's termination of employment or reduction in work hours, and then another COBRA qualifying event (other than termination of employment or reduction in work hours) occurs during the original COBRA Continuation Coverage period, that Dependent may continue coverage for up to 36 months, measured from the date of the initial qualifying event. However, for an event to operate as a *second* qualifying event, it must be an event that would have triggered a loss of coverage had it been the *initial* qualifying event. In no case will any period of COBRA Continuation Coverage exceed 36 months. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent, in writing, to the appropriate person described in Section 11.9. Please note that for the Employee's Medicare entitlement to be considered a second qualifying event for eligible Dependents, the Plan must provide that Medicare entitlement causes a loss of coverage for Dependents.

## 11.7 Special Continuation of Coverage Period for Medicare Entitlement

When an individual becomes entitled to Medicare and then, within 18 months thereafter, experiences a qualifying event that is loss of coverage due to termination of employment or reduction in work hours, the COBRA Continuation Coverage period for the Dependent spouse or Dependent children may continue for up to 36 months from the date of the Medicare entitlement.

## 11.8 Early Termination Of COBRA Coverage

Once a COBRA Qualified Beneficiary elects to continue coverage, coverage may continue for the period described above, unless:

- (a) In the case of a person entitled to 29 months of COBRA Continuation Coverage (due to his or another person's disability), the Social Security Administration determines that he (or such other person) is no longer disabled, in which case the extended Continuation Coverage will cease on the first day of the month that begins more than 30 days after the Social Security Administration makes such a determination;
- (b) If the person becomes entitled to Medicare, after the date he elects Continuation Coverage;
- (c) The person fails to make a required monthly payment within the 30 day grace period pursuant to this provision;
- (d) The person becomes covered - after the date he elects Continuation Coverage - under another employer group health plan (because of employment or otherwise) and that coverage contains no exclusion or limitation with respect to any pre-existing condition;

#### 11.4 Maximum Coverage Continuation Periods

Generally, coverage under COBRA may continue for up to:

- (a) Eighteen (18) months for an Employee or Dependent whose coverage would cease because of the Employee's termination of employment or reduction in work hours; or
- (b) Twenty-nine (29) months (i.e. 18 plus 11) for a disabled individual who:
  - (1) becomes entitled to the 18 months of continued coverage available after an Employee's termination of employment or reduction in work hours;
  - (2) is determined by the Social Security Administration to have been disabled on the date of that termination of employment or reduction in work hours or at any time during the first 60 days of COBRA Continuation Coverage; and
  - (3) notifies the Plan of that disability determination within 60 days after the person receives it and while still purchasing the first 18 months of COBRA Continuation Coverage.

Please note that a COBRA Qualified Beneficiary is eligible for this additional 11 months of coverage, even if not disabled, if he is entitled to COBRA Continuation Coverage due to the same qualifying event that entitles a disabled person to the additional 11 months of coverage.

- (c) Thirty-six (36) months, for a divorced or widowed spouse, or a child who has ceased to be a "Dependent" under the terms of the Plan.

#### 11.5 Special Second Election Period for Certain Trade-Displaced Individuals Who Did Not Elect COBRA Coverage

Special COBRA rights apply to Employees who lose health coverage as a result of termination or reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which the Employee begins receiving a trade readjustment allowance (or would be eligible to begin receiving the allowance but for the requirement to exhaust unemployment benefits) or begins receiving alternative trade adjustment assistance, but only if the election is made within the six months immediately after the Employee's group health plan coverage ended. The plan will not treat the period between the initial COBRA qualifying event and the first day of a special Trade Act COBRA election period as a break in creditable coverage for determining application of the plan's pre-existing condition exclusion.

## ARTICLE XI

### COVERAGE CONTINUATION RIGHTS

#### 11.1 Background

Eligible Employees and Dependents have the opportunity to continue their health coverage (e.g., medical, dental and vision, as the case may be) in certain instances where coverage would otherwise terminate. Such continuation coverage is as described in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and is therefore sometimes referred to as "COBRA Continuation Coverage."

#### 11.2 Entitlement And Qualifying Events

Under COBRA, a covered Employee or covered Dependent may elect to continue health coverage if that coverage would otherwise terminate due to a "qualifying event." Qualifying events are:

- (a) A covered Employee's termination of employment, for reasons other than gross misconduct, or reduction in work hours;
- (b) Death of the covered Employee;
- (c) Divorce or legal separation of the covered Employee and his spouse;
- (d) A covered eligible child's ceasing to satisfy the Plan's definition of eligible child;  
or
- (e) A covered Employee's entitlement to Medicare.

#### 11.3 COBRA Qualified Beneficiaries

A Qualified Beneficiary is an individual who is entitled to COBRA Continuation Coverage. In addition to those individuals covered under the Plan immediately preceding a qualifying event, a child born to a Qualified Beneficiary who is a former covered Employee or who is adopted by or placed for adoption with such a former covered Employee, during the Employee's period of Continuation Coverage, is also a Qualified Beneficiary.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event for certain retirees. If a proceeding in bankruptcy is filed by the Employer, and that bankruptcy results in the loss of coverage (if any) of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (although the Plan may disclose summary ePHI or enrollment-related ePHI to the Employer, without authorization, as further described below).

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

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

#### 10.4 Obligations of Employer Regarding Receipt and Use of ePHI

As a condition of receiving ePHI from the Plan for Plan administrative functions the Employer specifically agrees to:

- (a) 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;
- (b) Ensure that the adequate separation, between the ePHI and persons who have no legitimate need to access such ePHI, as required by 45 C.F.R. § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;
- (c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- (d) Report to the Plan any security incident of which it becomes aware.

## ARTICLE X

### HIPAA SECURITY PROTECTIONS

#### 10.1 Background

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) imposes upon this Plan and certain other entities certain responsibilities to ensure that Protected Health Information (“PHI”) that is *electronic* Protected Health Information (“ePHI”) pertaining to covered persons remains confidential, subject to limited exceptions in which ePHI may be disclosed.

“Protected Health Information” means health information that:

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

“Electronic Protected Health Information” is PHI that is transmitted by or maintained in electronic media, as defined in 45 C.F.R. § 160.103.

#### 10.2 Applicability and Effective Date

The rules contained in this Article do not apply to the Plan or the Employer until such date as the HIPAA Security regulations contained in 45 C.F.R. § 160.101 *et seq.* apply to the Plan. To the extent permitted by law, where the Plan includes one or more fully insured health care Component Program(s), and one or more self-insured health care benefit Component Program(s), the mere fact that fully insured and self-insured health care benefits are bundled under this Plan will not be construed to subject any fully insured medical benefit (absent the Employer’s acquisition of PHI with respect to the fully insured health care benefit) under this Plan to the same HIPAA privacy requirements that apply to the self-insured health care benefit Component Program(s).

#### 10.3 Disclosure of ePHI

Provided that the Plan (or the Employer on behalf of the Plan) provides to covered persons a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI to the Employer, the Plan may disclose ePHI (relating to a covered person) to the Employer, as further described below, without the consent or authorization of the covered person. In no event may the Plan disclose ePHI to the Employer without the consent or authorization of the covered person or his authorized representative, for purposes of

- (g) return or destroy (to the extent feasible) all copies of the PHI received from the Plan once the Employer's need for which the PHI was requested no longer exists or, if this is not feasible, limit further uses and disclosures of the PHI.

#### 9.5 Use And Disclosure Of PHI By The Employer; Dispute Resolution

When the Employer obtains PHI from the Plan for Plan administrative functions, the PHI will be provided to members of the Employer's designated HIPAA team, including the Employer's human resources/benefits department, payroll department and the Employer's chief financial officer and his designees. The persons in these departments, except as otherwise provided in a specific authorization granted by the Covered Person or his authorized representative to the Employer, will have access to and may use the PHI solely to perform Plan administrative functions that the Employer performs for or with respect to the Plan.

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

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

consent or authorization of the Covered Person or his authorized representative, for purposes of employment-related actions or decisions or in connection with any other benefit or Employee benefit plan of the Employer.

The Plan may disclose PHI to the Employer, without the consent or authorization of the Covered Person, subject to the Employer's obligations described below in Section 9.4 for Plan administrative functions such as wellness initiatives under the Plan, quality assurance, claims processing, auditing, and monitoring. However, only the minimum amount of PHI necessary to accomplish a particular Plan administration function may be disclosed to the person(s) performing such functions.

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

#### 9.4 Obligations of Employer Regarding Receipt and Use of PHI

As a condition of receiving PHI from the Plan for Plan administrative functions the Employer specifically agrees to:

- (a) not use or further disclose the PHI other than as permitted by this Plan or as required by law, or as permitted by the Covered Person to whom the PHI relates;
- (b) ensure that any agents or subcontractors to whom it shares or provides the PHI received from the Plan agree to these same restrictions and conditions;
- (c) not use the PHI for employment-related actions or in connection with any of its other benefit plans without the consent or authorization from the Covered Person to whom the PHI relates;
- (d) report to the Plan any improper uses or disclosures of the PHI;
- (e) provide Covered Persons access to PHI that relates to them, allow them to request amendments to the PHI, and upon request provide Covered Persons an accounting of all disclosures of their PHI by the Employer (except for those disclosures with respect to which no accounting is required);
- (f) make available to appropriate federal authorities the Employer's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan; and

## ARTICLE IX

### HIPAA PRIVACY PROTECTIONS

#### 9.1 Background

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) imposes upon the portion of this Plan providing health benefits, and certain other entities, certain responsibilities to ensure that Protected Health Information (“PHI”) pertaining to Covered Persons remains confidential, subject to limited exceptions in which PHI may be disclosed. “Protected Health Information” means health information (including oral information) that:

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

#### 9.2 Applicability and Effective Date

The rules contained in this Article do not apply to the Plan or the Employer until such date as the HIPAA Privacy Regulations (45 C.F.R. § 160.101 et seq.) apply to the Plan. The rules only apply to the portions of the Plan that provide medical care (e.g., medical, dental and vision care), and only to the extent such benefits are not “excepted benefits” under the HIPAA Privacy Regulations. The Plan Administrator may make a “hybrid entity designation” under which it has identified portions of the Plan that engage in functions covered by the HIPAA privacy rules, and the portions that do not. To the extent permitted by law, where the Plan includes one or more fully insured health care Component Program(s), and one or more self-insured health care benefit Component Program(s), the mere fact that fully insured and self-insured health care benefits are bundled under this Plan will not be construed to subject any fully insured medical benefit (absent the Employer’s acquisition of PHI with respect to the fully insured health care benefit) under this Plan to the same HIPAA privacy requirements that apply to the self-insured health care benefit Component Program(s).

#### 9.3 Disclosure of PHI

Provided that the Plan (or the Employer on behalf of the Plan) provides to Covered Persons a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI to the Employer, the Plan may disclose PHI (relating to a Covered Person) to the Employer, as further described below, without the consent or authorization of the Covered Person. In no event may the Plan disclose PHI to the Employer, without the

### 8.19 Mental Health Parity

Any financial requirements (such as deductibles, copayments, coinsurance and out-of-pocket expenses) and any treatment limitations (such as frequency of treatment, medical necessity determinations, number of visits and days of coverage) applied to mental health and substance abuse coverage under a Component Program that is a health plan may not be more restrictive than the limitations applied to comparable medical and surgical coverage under the health plan. More information is available in the benefit booklet.

### 8.20 Women's Health and Cancer Rights

The health benefits available through the Plan will comply with the Women's Health and Cancer Rights Act of 1998, which requires the provision of coverage for breast reconstruction in connection with mastectomy as follows, subject to plan deductibles and coinsurance, if any:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

### 8.21 Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act prohibits using genetic information to discriminate with respect to health benefits. The health plans and insurers are prohibited from (1) restricting enrollment or adjusting premiums based on genetic information; and (2) requiring or requesting genetic information or genetic testing prior to or in connection with enrollment.

#### 8.14 Workers' Compensation

This Plan is not in place of and does not affect any requirement for coverage by workers' compensation insurance, unless this Plan specifically provides that it is in place of, and affects, a requirement for such insurance.

#### 8.15 Managed Care Directories

To the extent any Component Document hereunder provided health benefits under one or more managed care networks, a directory of network providers may be furnished or made available to each Eligible Employee in writing or electronically. However, upon written request, each Eligible Employee will receive, at no cost, a written directory of network providers, which may be provided in a separate document.

#### 8.16 Time for Bringing Actions Against the Plan

Except to the extent provided under the terms of a Component Document where such terms are required by applicable law, no legal action may be brought to recover from or with respect to this Plan prior to the earlier of (i) the date the claimant has exhausted all administrative remedies under this Plan, and (ii) the date that is eighteen months from the time written proof of loss is required to be given.

#### 8.17 Newborns' and Mothers' Health Protection Act

With respect to Component Programs that would separately be considered group health plans, the Plan will comply with the Newborns' and Mothers' Health Protection Act. Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

#### 8.18 CHIPRA Special Enrollment Rights

CHIPRA provides you with a 60-day special enrollment right to enroll in a Component Benefit that is a group health plan under the following two circumstances: (1) your coverage or coverage of your dependent under Medicaid or a state-sponsored children's health insurance program ("CHIP") terminates due to loss of eligibility; and (2) you or your dependent becomes eligible for state financial assistance under Medicaid or CHIP to help pay for coverage under the Employer's group health plan(s).

telegrams) to, or when mailed by first-class mail, postage prepaid and addressed to, such Employee, or other person at the address last appearing on the Employer's records.

8.7 Masculine and Feminine, Singular and Plural

Whenever used herein, a pronoun will include the opposite gender and the singular will include the plural, and the plural will include the singular, whenever the context will plainly so require.

8.8 Severability

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

8.9 Governing Law

This Plan will be construed in accordance with applicable federal law and to the extent otherwise applicable, the laws of the State of Missouri.

8.10 Disclosure to Covered Persons

To the extent required by law, each Covered Person will be advised of the general provisions of the Plan and, upon written request addressed to the Plan Administrator, will be furnished any information requested regarding the Covered Person's status, rights and privileges under the Plan as may be required by law.

8.11 Accounting Period

The accounting period for the Plan will be the Plan Year.

8.12 Facility of Payment

In the event any benefit under this Plan will be payable to a person who is under legal disability or is in any way incapacitated so as to be unable to manage his or her financial affairs, the Plan Administrator may direct payment of such benefit to a duly appointed guardian, committee or other legal representative of such person, or in the absence of a guardian or legal representative, to a custodian for such person under a Uniform Gifts to Minors Act or to any relative of such person by blood or marriage, for such person's benefit. Any payment made in good faith pursuant to this provision will fully discharge the Employer and the Plan of any liability to the extent of such payment.

8.13 Correction of Errors

In the event an incorrect amount is paid to or on behalf of a Covered Person or beneficiary, any remaining payments may be adjusted to correct the error. The Plan Administrator may take such other action it deems necessary and equitable to correct any such error.

## ARTICLE VIII

### GENERAL PROVISIONS

#### 8.1 Plan Interpretation

This Plan document, including the attached Appendices and Component Documents incorporated herein by reference, sets forth the provisions of this Plan. This Plan will be read in its entirety and not severed except as provided in Section 8.8. The provisions of this document will control over the provisions of any Component Document, except to the extent this document expressly provides to the contrary.

#### 8.2 Participation by Affiliated Employers

The Employer may permit any of its Affiliated Employers or Participating Non-Controlled Group Employers to participate in one or more benefits under the Plan.

#### 8.3 Non-Alienation of Benefits

No benefit, right or interest of any person hereunder will be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law. However, the Plan will recognize and comply with any Qualified Medical Child Support Order.

#### 8.4 No Additional Rights

No person will have any rights under the Plan, except as, and only to the extent, expressly provided for in the Plan. Neither the establishment or amendment of the Plan or the creation of any fund or account, or the payment of benefits, nor any action of the Employer or the Plan Administrator will be held or construed to confer upon any person any right to be considered or continued as an Employee, or, upon dismissal, any right or interest in any account or fund other than as herein provided. The Employer expressly reserves the right to discharge any Employee at any time.

#### 8.5 Representations

The Employer does not represent or guarantee that any particular federal or state income, payroll, personal property, Social Security or other tax consequences will result from participation in this Plan. A Covered Person should consult with professional tax advisors to determine the tax consequences of participation.

#### 8.6 Notice

All notices, statements, reports and other communications from the Employer to any Employee or other person required or permitted under the Plan will be deemed to have been duly given when delivered (including facsimile transmission, email, telex, and

to the extent permitted by applicable law, unless otherwise specified in the Component Documents for such benefit.

## ARTICLE VII

### AMENDMENT AND TERMINATION

#### 7.1 Amendment or Termination

The Employer establishes this Plan with the intention that it will be maintained indefinitely; however, the Employer reserves the right at any time and from time to time to amend any or all of the provisions of the Plan, or terminate the Plan and/or Employer contributions thereunder, in whole or in part, for any reason and without consent of any person and without liability to any person for such amendment or termination, provided that the payment of claims that are incurred at the time of any such amendment or termination will not be adversely affected.

Any amendment of the Plan will be made in writing and will be approved by the Employer and executed by a duly-authorized representative of the Employer, provided that an amendment of any of the Appendices may be made by the Plan Administrator or its authorized representative. Because the Plan can only be amended by a written instrument, no person may rely on any oral statements or representations by any other person that attempt or purport to alter the provisions of the Plan or the benefits described in this Summary or any other written Plan document. Nothing in this Plan will be construed to require continuation of this Plan with respect to existing or future Covered Persons or beneficiaries.

Any insurer providing benefits under this Plan under the terms of a Component Document may amend such Component Document as and to the extent provided therein.

Where a change to a Component Document affects the information described in one or more Appendix, then the Appendix may be updated in accordance with the change to the Component Document without resorting to the formalities of a formal amendment. For example, if a Component Document is amended or replaced with a similar document (e.g., a group insurance contract is replaced by a similar contract issued by the same or different insurer), or where the claims administrator for a particular Component Program is changed, the Employer may, without resorting to the formalities of a formal amendment, replace the Appendices attached hereto with Appendices reflecting the updated information regarding the Component Document or its issuer.

#### 7.2 Exclusive Purpose of Providing Benefits to Covered Persons

The Employer establishes this Plan for the exclusive benefit of Covered Persons. No Plan amendment or termination will be made which would cause or permit benefits to be provided other than for the exclusive benefit of such individuals, unless such amendment is made to comply with federal or local law.

#### 7.3 Surplus Assets After Plan Termination

If a benefit is terminated and surplus assets attributable to that benefit remain after all liabilities regarding such benefit have been paid, such surplus will revert to the Employer

- (v) An Employer or multiemployer Plan or Employee welfare benefit Plan;
- (vi) A governmental medical benefit program;
- (vii) Insurance required or provided by statute;
- (viii) Automobile, no-fault, homeowners or general liability insurance (not merely the medical expense benefit provisions of such insurance);
- (ix) Settlement or judgment proceeds (regardless of the manner in which such proceeds are characterized).

The term "Other Plan" does not include any individual health insurance policies or contracts, or public medical assistance programs such as Medicaid, except as otherwise provided herein. The term "Other Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of Other Plans into consideration in determining its benefits and that portion which does not.

- (c) "Person" means any individual, association, partnership, corporation or any other organization.

Plan's exclusion of otherwise Covered Expenses which have not been paid at the time the Covered Person receives compensation for the injury or sickness that gave rise to the expenses.

#### 6.7 Constructive Trust

In the event the Plan, pursuant to these reimbursement and subrogation provisions, is entitled under such provisions to be reimbursed for benefits it has paid for treatment of a Covered Person's sickness or injury, and where the Covered Person or someone (including an individual, estate or trust) on behalf of the Covered Person receives or is entitled to receive compensation for such sickness or injury from some other source, the Plan will have a constructive trust on such compensation to the extent of the benefits paid by this Plan. Such constructive trust will be imposed upon the person or entity then in possession of such compensation.

#### 6.8 Right To Receive And Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this Plan or any Other Plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which the Plan Administrator deems to be necessary for such purposes, with respect to any person claiming benefits under this Plan. Any person claiming benefits under this Plan will furnish to the Plan Administrator such information as may be necessary to implement this provision.

#### 6.9 Special Definitions

For purposes of this Article VI, the following special definitions will apply:

- (a) "Covered Person" means a Covered Person as defined in Article I, or a participating coverage continuation beneficiary who meets the eligibility requirements for coverage as specified in this Plan and is properly enrolled under the Plan.
- (b) "Other Plan" includes, but is not limited to, any of the following providing payments on account of an injury or Sickness:
  - (i) Any group, blanket or franchise health insurance, or coverage similar to same;
  - (ii) A group contractual prepayment or indemnity Plan, or coverage similar to same;
  - (iii) A Health Maintenance Organization (HMO), whether group practice or individual practice association;
  - (iv) A labor-management trusted Plan or a union welfare Plan;

Plan Administrator may, within its sole discretion, apportion the monies such that this Plan receives less than full reimbursement.

#### 6.5 Implementation

The Plan Administrator will determine which of the Plan's rights and remedies it is within the best interests of this Plan to pursue. The Plan Administrator may agree to recover less than the full amount of excess payments or to accept less than full reimbursement if (1) this Plan has made, or caused to be made, such reasonable, diligent and systematic collection efforts as are appropriate under the circumstances; and (2) the terms of such agreement are reasonable under the circumstances based on the likelihood of collecting such monies in full or the approximate expenses this Plan would incur in an attempt to collect such monies.

#### 6.6 Subrogation/Reimbursement Agreement

To the extent permitted by applicable law, except as otherwise provided herein (*e.g.*, the coordination rules regarding automobile insurance), if a Covered Person incurs an injury or sickness under circumstances where compensation may be payable to the Covered Person by some Other Plan or Person (as defined in this Article), the Plan may agree to pay benefits for that injury or sickness to the extent otherwise payable under the Plan, provided the Covered Person or someone legally qualified and authorized to act for the Covered Person in writing:

- (a) Consents to the Plan's subrogation of any recovery or right of recovery the Covered Person has with respect to the injury or sickness;
- (b) Promises not to take any action that would prejudice the Plan's subrogation rights;
- (c) Promises to reimburse the Plan for any such benefits payments to the extent that the Covered Person receives a recovery from an Other Plan or Person, irrespective of how the recovery is made or characterized, and irrespective of whether the recovery is sufficient to make the Covered Person whole. This reimbursement must be made within 30 days after the Covered Person (or anyone on his or her behalf) receives the payment; and
- (d) Promises to cooperate fully with the Plan in asserting its subrogation rights and supply the Plan with any and all information and execute any and all forms the Plan may need for this purpose.

In the event the Covered Person fails to, or refuses to, execute whatever assignment, form or document requested by the Plan Administrator or its designee, the Plan will be relieved of any and all legal, equitable or contractual obligation for any benefits or Covered Expense incurred by the Covered Person and each member of the Covered Person's family, including claims then incurred but unpaid.

Nothing in this Reimbursement Agreement provision will be construed to prevent application of the provisions of the Reimbursement provisions above, regarding the

after the date on which the compensation was paid, or which were incurred before such date but not paid by the Plan as of such date, will be excluded from coverage under the Plan to the extent of the excess (if any) of the compensation received by or on behalf of the Covered Person, over the covered expenses which the Plan has already paid for treatment of the injury or sickness.

This Plan will not be responsible for any costs or expenses (including attorneys' fees) incurred by or on behalf of a Covered Person in connection with any recovery from any Other Plan or Person unless this Plan agrees in writing to pay a part of those expenses. The characterization of any amounts paid to or on behalf of a Covered Person, whether in a settlement agreement or otherwise, will not affect this Plan's right to reimbursement and to characterize otherwise covered charges as excludable covered expenses pursuant to these provisions.

#### 6.4 Subrogation

To the extent permitted by applicable law, the Plan will be subrogated, to the extent of benefits paid or payable by this Plan, to any monies (*i.e.*, "first dollar" monies) paid or payable by any Other Plan or Person by reason of the injury or sickness which occasioned or would occasion the payment of benefits by this Plan, whether or not those monies are sufficient to make whole the Covered Person to whom or on whose behalf this Plan made its payments or to whom or on whose behalf this Plan's payments are payable. The Plan will not be responsible for any costs or expenses, including attorneys' fees, incurred by or on behalf of a Covered Person in connection with any efforts to recover monies from any Other Plan, unless this Plan agrees in writing to pay a portion of those expenses. The characterization of any amounts paid to or on behalf of a Covered Person, whether under a settlement agreement or otherwise, will not affect this Plan's right to subrogation and to claim, pursuant to such right, all or a portion of such payment.

These subrogation provisions will not be construed to prevent the Plan, in its sole discretion, from obtaining full satisfaction of its subrogation lien from the Covered Person (or, in the Plan's sole discretion) any other Person who received payment on behalf of the Covered Person, such as a parent or guardian) by, for example, apportioning liability for satisfaction of the subrogation lien among the Covered Person and any other Person, such as the Covered Person's legal counsel.

This Plan will also be subrogated to the extent of benefits paid under this Plan to any claim a Covered Person may have against any Other Plan or Person for the injury or sickness that occasioned the payment of benefits under this Plan. Upon written notification to the Covered Person, this Plan may (but will not be required to) collect the claim directly from the Other Plan or Person in any manner this Plan chooses without the Covered Person's consent. This Plan will apply any monies collected from the Other Plan or Person to payments made under this Plan and to any reasonable costs and expenses (including attorneys' fees) incurred by this Plan in connection with the collection of the claim up to the amount of the award or settlement. Any balance remaining will be paid to the Covered Person as soon as administratively practical. The

future, under this Plan to one or more of the Covered Person, Plans, persons, providers, insurance companies, or other organizations as listed above.

For example, but not by way of limitation, if this Plan pays a claim submitted by a Covered Person or by a health care provider who treated the Covered Person, and the Plan Administrator or its designee later determines that the claim was for an expense not covered under this Plan, the Plan is entitled to recover the payment from the Covered Person or the provider, or to recover part of the payment from the Covered Person and part from the provider, or set-off the amount of the payment from amounts the Plan may owe in the future to the Covered Person or the provider, or both. This same rule applies if the Plan makes payment to a Covered Person or a provider of an expense that is a Covered Expense, but the amount so paid exceeds the amount the Plan requires be paid.

These reimbursement provisions also apply where this Plan makes payments of covered expenses incurred for treatment of an injury or sickness for which any Other Plan or Person is or may be liable, and where this Plan's subrogation provisions do not provide this Plan with a right to recover amounts this Plan pays or may pay for treatment of the injury or sickness. If the Other Plan or Person makes payment to or on behalf of a Covered Person as compensation for the injury or sickness, and this Plan is not subrogated with respect to the payment, this Plan is entitled to reimbursement from the Covered Person (or anyone who received such payment on behalf of the Covered Person), from the payment made by the Other Plan or Covered Person, in an amount equal to the lesser of (i) the benefits paid by this Plan for treatment of the injury or sickness, or (ii) the amount of the payment made by the Other Plan or Covered Person. This provision will not apply where the Other Plan is a medical plan with respect to which this Plan, pursuant to its coordination of benefits provisions, is the primary payer of the Covered Person's covered expenses.

These reimbursement provisions will not be construed to prevent the Plan, in its sole discretion, from obtaining full reimbursement from the Covered Person (or, in the Plan's sole discretion) any other person who received payment on behalf of the Covered Person, such as a parent or guardian) by, for example, apportioning the obligation to reimburse the Plan among the Covered Person and any other person, such as the Covered Person's legal counsel. The preceding sentence is specifically intended to avoid requiring the Plan, in order to obtain full reimbursement, to seek reimbursement from any person (such as the Covered Person's legal counsel) other than the Covered Person (or the Person, such as a parent or legal guardian, who received payment on behalf of the Covered Person) where the Plan can be made whole entirely from amounts actually received by the Covered Person (or the Person, such as a parent or legal guardian, who received such amounts on behalf of the Covered Person). This same rule will apply to the Plan's rights to set-off as described above.

In addition, where an Other Plan or Person pays compensation to or on behalf of a Covered Person for an injury or sickness for which an Other Plan or Person is or may be liable, and the Covered Person incurs (either before or after payment of such compensation) otherwise covered expenses for treatment of the injury or sickness, a special rule applies. In such a case, such otherwise covered expenses that were incurred

## ARTICLE VI

### RIGHT TO RECOVERY, REIMBURSEMENT, SUBROGATION AND SET-OFF

#### 6.1 Applicability

The provisions of this Article VI apply to the extent the reimbursement and subrogation terms of an applicable Component Document do not supply greater rights to the Plan. If the reimbursement and subrogation terms of an applicable Component Document supply greater rights, the terms of such Component Document will apply. For purposes of this Article, a Component Document is “applicable” if benefits under the Component Document are the subject of a reimbursement or subrogation claim by this Plan. For purposes of this Article, a law will not be considered an “applicable law” if it is preempted by ERISA.

#### 6.2 Corrective Payments

To the extent permitted by applicable law, whenever payments that should have been made under this Plan in accordance with the coordination of benefits provisions have been made under any Other Plans, this Plan will have the right to pay to any persons making such other payments any amounts they determine to be warranted in order to satisfy the intent of the coordination of benefits provisions. Amounts so paid will be deemed to be benefits paid under this Plan, and to the extent of such payments, this Plan will be fully discharged from liability.

#### 6.3 Reimbursement

To the extent permitted by applicable law, whenever this Plan makes payments that together with the payments the Covered Person has received or is entitled to receive from any Other Plan or Person, exceed the maximum amount necessary to satisfy the intent of this provision; or exceed, under the terms of this Plan, the benefits properly payable to or on behalf of the Covered Person, Plan, provider, or person to or for or with respect to whom the payments were made, this Plan will have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan Administrator in its sole discretion will determine:

- (a) The Covered Person;
- (b) If the Covered Person is an eligible Dependent or former eligible Dependent, the Covered Person or former Covered Person with respect to whom the Covered Person is or was an eligible Dependent;
- (c) Any Other Plan, provider, or person to or for or with respect to whom such payments were made;
- (d) Any insurance company or Other Plan or Person that should have made the payment; and
- (e) Any other organizations.

Alternatively, the Plan Administrator or its designee may set-off the amount of such payments, to the extent of such excess, against any amount owing, at that time or in the

date the determination was made that the order is a Qualified Medical Child Support Order. In the case of a national medical support notice, if there are multiple coverage options available to the child under the Plan the state agency issuing the notice will select an option, but if it fails to do so within twenty (20) days after the Plan Administrator's (or designee's) notice described in the preceding paragraph, the child will be enrolled under the Plan's default option (if any).

Unless the Qualified Medical Child Support Order provides otherwise, the Participant will be responsible to make any required contribution to pay for such coverage. In no event will coverage provided under a Qualified Medical Child Support Order become effective for a child prior to the date the Order is received by the Plan.

If the Plan Administrator or its designee determines that the medical child support order is not "qualified," a written determination to that effect will be furnished to the Participant and the child or the child's representative. The Participant or the child (or the child's representative) may appeal the determination to the Plan Administrator or its designee. Any request for review of a determination must be filed with the Plan Administrator or its designee within sixty (60) days after the Plan Administrator or its designee issues its original determination.

For purposes of this Section, a "Qualified Medical Child Support Order" is an order issued by a court having proper jurisdiction, or issued under an administrative process established under state law that has the force and effect of law under applicable state law and which creates or recognizes the existence of a child's rights to, or assigns to such child the right to, receive health benefits for which a Dependent is eligible under this Plan, provided such order clearly specifies: (i) the name and last known mailing address of the Employee, and the name and mailing address of each child covered by the order (to the extent provided in the order, the name and mailing address of an official of the state agency issuing the order may be substituted for the name and mailing address of the child); (ii) a reasonable description of the type of coverage to be provided by the Plan to each child, or the manner in which coverage is to be determined; (iii) the time period to which such order applies; and (iv) meets other legal requirements. A national medical support notice that meets (or, pursuant to federal regulations, is deemed to meet) the foregoing requirements will be considered a Qualified Medical Child Support Order.

assure compliance with applicable bonding requirements. The Plan Administrator may apply for and obtain fiduciary liability insurance insuring the Plan against damages by reason of breach of fiduciary responsibility and insuring each fiduciary against liability to the extent permissible by law at the Employer's expense.

#### 5.11 Qualified Medical Child Support Orders

The Plan will honor the terms of a Qualified Medical Child Support Order with respect to Component Programs that are subject to such Order. Qualified Medical Child Support Orders are typically issued in or after divorce proceedings, and may create or recognize the right of a child to be covered under this Plan (specifically, to be covered under a Component Plan providing health benefits).

Medical child support orders will be evaluated by the Plan Administrator or such other person or entity specified in the applicable Component Documents and will be approved or denied. The Plan Administrator (or such other person or entity specified in the applicable Component Documents) will, promptly after receiving a medical child support order, notify the Participant and each child designated in the order. The notification will contain information that permits the child to designate a representative for receipt of copies of notices that are sent to the child with respect to a medical child support order.

As soon as administratively possible following receipt of the order (or, in the case a national medical support notice, within 40 days of notice) the Plan Administrator (or such other person or entity specified in the applicable Component Documents) will determine whether the order is a "qualified" medical child support order. Upon determination of whether a medical child support order is or is not qualified, the Plan Administrator (or such other person or entity specified in the applicable Component Documents) will send a written copy of the determination to the Participant and each child (or, where an official of the state agency issuing the order is substituted for the name of the child, notify such official).

If the Plan Administrator (or such other person or entity specified in the applicable Component Documents) determines that the medical child support order is qualified, the Participant, the child or his representative must furnish to the Plan Administrator or its designee any required enrollment information. In the case of a national medical support notice, the Plan Administrator or its designee will: (i) notify the state agency issuing the notice whether coverage is available to the child under the Plan and, if so, whether such child is covered under the Plan and either the effective date of such coverage or any steps to be taken by the child's custodial parent or an official of the state agency that issued the notice to effectuate such coverage, and (ii) provide the custodial parent (or, where an official of the state agency issuing the order is substituted for the name of the child, notify such official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

The Participant is responsible for notifying the Plan Administrator of the necessary enrollment information within the timeframe(s) specified in the applicable Component Program, but generally, in no more than forty-five (45) days immediately following the

- the adverse determination was not due to ineligibility of the Claimant;
  - the Claimant exhausted any required internal appeal process; and
  - the Claimant has provided all information required.
- (3) The Plan will issue notice to the Claimant within one business day after the Plan's preliminary review of the request for external review. If the Claimant is not eligible for external review, the notice must include reasons for ineligibility and contact information for the Employee Benefit Security Administration. If the request for external review is not complete, the notice must describe information that is needed and allow the claimant to complete or perfect his request within the four-month filing period described above or 48 hours, whichever is later.
- (4) If the request for external review is appropriate, the Plan will refer the appeal to an Independent Review Organization (IRO), with which the Plan has contracted in accordance with applicable federal regulations. The IRO will conduct its review and supply appropriate notices in accordance with applicable federal standards. If the IRO reverses the Plan's decision, the Plan will provide coverage or payment upon receipt of notice of the IRO's decision, without delay and without regard to the Plan's intention to seek judicial review.
- (5) The Plan will make available, to the extent required by and in accordance with applicable federal law, an expedited external review process where a Claimant receives an adverse determination or final internal adverse determination and where completion of an expedited internal appeal or standard external review would seriously jeopardize the life or health of the Claimant.

(d) No Conflicts of Interest

The Plan will adjudicate claims in a manner ensuring the independence and impartiality of those involved in decision-making. For example, the Plan may not hire, promote, provide incentives to or terminate the employment of individuals based on their support of a denial of benefits or on the number of claims denied.

5.9 Expenses

Unless specified otherwise in a Component Document, the Employer will pay all reasonable expenses that are necessary to operate and administer the Plan.

5.10 Bonding and Insurance

To the extent required by law, every fiduciary of the Plan and every person handling Plan funds will be bonded. The Plan Administrator will take such steps as are necessary to

(b) Additional Requirements Related to Access to Information Pending Decision on Appeal

In connection with any appeal of an adverse determination, the Claimant or a duly authorized representative of the Claimant will have the right to examine the Claimant's claim file, and to present evidence and testimony as part of the review process. The Claimant will receive, free of charge, any new or additional evidence considered, relied upon or generated by the Plan in connection with its review of an appeal of an adverse determination, and any new or additional rationale the Plan intends to rely upon in deciding the internal appeal, sufficiently in advance of the final decision on the internal appeal to allow the Claimant an opportunity to respond prior to the decision.

(c) Additional Requirements Related to External Review of Final Action on Internal Appeal

Different external review rules apply depending on whether the relevant health care coverage is subject to a state insurance law external review requirement that meets standards specified in federal regulations, or whether the coverage is not subject to such a state law.

Where the relevant health care coverage is subject to a state standard that complies with applicable federal regulations (or is deemed to comply during any transition period under such regulations), such state standard will apply to the insurer (where the coverage is insured) or the Plan (where the coverage is self-insured). Where the relevant health care coverage is not subject to a state standard, or subject to a state standard that does not meet federal regulatory requirements (taking into account any period of deemed compliance during a transition period provided for under federal regulations), then the following rules apply to the Plan to the extent and as of the date required by applicable federal regulations:

- (1) A Claimant may file a request for external review within 4 months of receipt of notice of an adverse determination (to the extent permitted by applicable law, however, the Plan may require the Claimant to exhaust any reasonable internal appeal process); for this purpose, and to the extent permitted by applicable federal regulations, an "adverse determination" means an adverse determination as defined elsewhere in these provisions, but only to the extent it involves medical judgment or a retroactive rescission of coverage.
- (2) Within 5 business days following receipt of the request for external review, the Plan will determine whether:
  - the Claimant was covered under Plan and applicable health care coverage when the health care item or service was requested (or provided, where the review is a for a post-service claim);

out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.” (However, this latter statement is not required if there is no alternative dispute resolution process (e.g., arbitration).)

The decision will be final and binding upon the Claimant and all other persons involved, except to the extent otherwise provided under applicable law.

5.8 Additional Requirements for Non-Grandfathered Health Care Coverage Subject to the Patient Protection and Affordable Care Act of 2010

For health care claims under non-grandfathered health care coverage subject to the Patient Protection and Affordable Care Act of 2010, the following additional rules apply.

(a) Additional Requirements for Notice of Initial Adverse Determination and Notice of Final Action on Internal Appeal

Any notice of initial adverse determination or notice of final action on an internal review of an adverse determination must include the following additional information:

- the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and the treatment code and their corresponding meanings (the Plan will supply this information related to the diagnosis and treatment codes as soon as practicable following such a request, and will not consider such request to be a request for an internal appeal or, as applicable, external review);
- the standard, if any, used in denying the claim in whole or in part (i.e., a discussion of an applied “medical necessity” standard);
- a description of the available internal and external appeals procedures, including information about how to initiate an appeal; and
- the availability of—and contact information for—any applicable office of health insurance consumer assistance or ombudsman established under the Act to assist individuals with the internal claims and appeals and external review procedures.

The notices described above must be supplied in a “culturally and linguistically appropriate” manner, pursuant to and to the extent required by applicable federal regulations.

must be made within 72 hours for a claim involving urgent health care, 30 days for a pre-service health care claim, 45 days for a disability claim, or 60 days for a post-service health care claim or claim for a benefit other than a health care or disability benefit; the time period begins to run on the date the appeal is received by the Plan. The Claimant may agree to extend these deadlines.

The decision on review may be delayed for up to 45 days (in the case of a disability benefit claim) or 60 days (in the case of a claim other than for a disability benefit) where special circumstances require the delay, and such delay is permitted by federal regulations. The Plan Administrator or its delegate will provide notice of the extension, and the reason therefore, to the Claimant prior to the end of the initial review period.

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

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- a statement that the Claimant is entitled to receive without charge reasonable access to any document (1) relied on in making the determination; (2) submitted, considered or generated in the course of making the benefit determination; (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination; or (4) in the case of a group health Plan or disability Plan, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
- a statement of any voluntary appeals procedures and the Claimant's right to receive information about the procedures as well as the Claimant's right to bring a civil action under Section 502(a) of ERISA;
- a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that this will be provided without charge upon request; and
- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find

- a description of the Plan's review procedures, including the Claimant's right to bring a civil action under Section 502(a) of ERISA;
- (for health care and disability claims) a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;
- (for health care and disability claims) if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that this will be provided without charge upon request; and
- in the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims.

(d) Right to Request Review

Any person who has had a claim for benefits denied in whole or in part by the Plan Administrator or its delegate, or is otherwise adversely affected by action of the Plan Administrator or its delegate, will have the right to request review by the Plan Administrator. Such request must be in writing, and must be made within 180 days (for health care and disability benefit claims) or 60 days (for other claims) after such person is advised of the Plan Administrator's (or its delegate's) action. If written request for review is not made within such 180-day (or 60-day, as the case may be) period, the Claimant will forfeit his or her right to review. The Claimant or a duly authorized representative of the Claimant may review all pertinent documents and submit issues and comments in writing. The Plan Administrator may prescribe a reasonable procedure under which a Claimant may designate an authorized representative.

(e) Review of Claim

The Plan Administrator or its delegate will then review the claim. The person or entity that reviews the claim must be a named fiduciary under the Plan, and (in the case of reviews of health care or disability claims) may not be the same person, or a person subordinate to the person, who initially decided the claim. If in the case of a health care or disability claim the adverse determination was based on medical judgment, the person handling the appeal must consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved, and such professional may not be the same professional who was consulted with respect to the initial action on the claim.

The person or entity deciding the appeal may hold a hearing if it deems it necessary and will issue a written or electronically disseminated decision reaffirming, modifying or setting aside its former action. The decision on appeal

(5) Disability Benefit Claim

The “applicable period” for a disability benefit claim is 45 days after receipt of the claim by the Plan. If the Plan requires additional time to process the claim, it may extend the applicable period by up to two (2) thirty-day extensions, but the Plan Administrator or its delegate will notify the Claimant of the need for the extension prior to the beginning of any such extension period.

(6) Special Rule for Retroactive Health Care Coverage Rescissions

Where health care coverage subject to the Patient Protection and Affordable Care Act of 2010 is rescinded retroactively (for reasons other than failure to pay premiums or due to routine administrative delays in processing coverage additions and deletions), in addition to any other notice that may be required by these provisions the Plan will supply written notice of the rescission to each affected participant not fewer than 30 days prior to the effective date of the rescission.

(7) Other Claims

The “applicable period” for a benefit claim not described in subsections (1) to (5) above is 90 days after receipt of the claim by the Plan. If the Plan requires additional time to process the claim, it may extend the applicable period by up to 90 days, but the Plan Administrator or its delegate must notify the Claimant of the need for the extension prior to the beginning of any such extension period.

(c) Form and Content of Notice of Adverse Determination on Claims

If a claim is denied in whole or in part, notice of such adverse determination must be provided to the Claimant. Notice must be written or electronic; oral notice is permitted with respect to urgent care claims, but only if written or electronic confirmation is furnished to the Claimant within three (3) days after the oral notice is provided.

The notice must include the following:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- if applicable, a description of any additional information needed for the Claimant to perfect the claim and an explanation of why such information is needed;

(3) “Concurrent” Health Care Claims

A concurrent health care claim may be either an urgent care claim or a pre-service claim. Generally, it is a claim for an ongoing course of health care treatment to be provided over a period of time or number of treatments. An adverse determination involving concurrent care must be made sufficiently in advance of any reduction or termination in treatment to allow the Covered Person to appeal the adverse determination. If a course of treatment involves urgent care, a request by the Claimant to extend the course of treatment must be decided as soon as possible, but not later than 24 hours after receipt of the request by the Plan, provided that the request is made at least 24 hours prior to the expiration of treatment.

Expiration of an approved course of treatment is not an adverse determination under these rules. However, any reduction or termination by the Plan of the course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments originally prescribed is an adverse determination and may be appealed. Notice must be provided a reasonable time before the treatments will stop; however, the Plan is not required to allow the Claimant the 180 days to appeal the Plan’s decision, before the Plan may terminate the treatment. Coverage must continue during the pendency of an appeal of an adverse determination involving a concurrent care claim to the extent required by, and in accordance with, applicable federal law.

(4) “Post-Service” Health Care Claim

A post-service health care claim is a claim that is not an urgent care, pre-service or concurrent care claim. The “applicable period” for a post-service claim is 30 days after receipt of the claim by the Plan. The Plan Administrator may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Plan Administrator or its delegate must notify the Claimant within the timeframe of the reason for the extension and the date by which the Plan expects to render its decision.

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

the period necessary to decide the matter (that is, “as soon as possible”), but in no event longer than 72 hours. Whether a claim involves “urgent care” (as defined in federal regulations) will be determined by the Claimant’s attending physician, and the Plan will defer to the judgment of the Claimant’s physician.

If the Plan cannot render a decision within this timeframe because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan Administrator or its delegate must notify the Claimant within 24 hours of the specific information needed to complete the claim. The Claimant must be given at least 48 hours to provide the required information. Within 48 hours after the earlier of (1) the Plan’s receiving the required information or (2) the expiration of the period afforded to the Claimant to provide the information, the Plan Administrator or its delegate must notify the Claimant of the Plan’s benefit determination. The Claimant may agree to extend these deadlines.

An appeal of an adverse determination regarding an urgent care claim (where the claim is still an urgent care claim) must be decided as soon as possible, but no later than 72 hours after the Plan receives the request for review or appeal. Other requirements apply to the processing of appeals by non-grandfathered healthcare coverage subject to the Patient Protection and Affordable Care Act of 2010. See below.

(2) “Pre-Service” Health Care Claims

A pre-service health care claim is any request for approval of health care coverage for a service or item that under the terms of the Plan requires advance approval. The “applicable period” for a pre-service claim is 15 days after receipt of the claim by the Plan. The Plan Administrator may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Plan Administrator or its delegate must notify the Claimant within the timeframe of the reason for the extension and the date the Plan expects to render its decision.

If the Claimant has not followed the Plan’s procedures for filing a pre-service claim, the Plan must notify the Claimant within 5 days of the proper procedures to be followed in order to complete the claim. Further, if the Plan cannot render a decision within 15 days because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension must describe the specific information needed to complete the claim; the Claimant must be given at least 45 days from receipt of the notice to provide the required information; and the Plan has 15 days from the date of receiving the Claimant’s information to render its decision. The Claimant may agree to extend these deadlines.

## 5.7 Claims Procedure

A Covered Person will apply for Plan benefits in writing on a form provided by the Plan Administrator or its delegate, unless a claim is filed directly by a provider of benefits. A claim for reimbursement of expenses must be submitted in a manner and within the time period specified in the applicable Component Documents. Claims will be evaluated by the Plan Administrator or such other person or entity specified in the applicable Component Documents and will be approved or denied in accordance with the terms of the Plan including the Component Documents.

The following claims procedures will apply, but only to the extent the applicable Component Document does not apply at least as extensive procedures. If the claim and appeal rules in this document apply, they will be construed and applied in a manner consistent with applicable federal regulations as in effect on the date the claim was received:

### (a) Notice of Action

Any time a claim for benefits receives an adverse determination, the Employee or beneficiary (“Claimant”) will be given written notice of such action within the “applicable period” after the claim is filed, unless special circumstances require an extension of time for processing. If there is an extension, the Claimant will be notified of the extension and the reason for the extension within the initial applicable period. If any urgent care or pre-service claim is approved, the Claimant will be notified of such approval and provided sufficient information to understand the import of the approval.

An “adverse determination” means a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for a benefit, where the action is based on a determination of an individual’s eligibility, a determination that a benefit is not a covered benefit, the imposition of an exclusion or limitation, or a determination that a benefit is experimental, investigational or not medically necessary or appropriate. An adverse determination includes retroactive rescission of coverage (for reasons other than failure to pay premiums or due to routine administrative delays in processing coverage additions and deletions).

### (b) Categories of Claims, “Applicable Periods,” and Extensions

#### (1) “Urgent” Health Care Claims

Urgent health care claims are requests for verification or approval of coverage for health care or treatment where, if the request were not handled expeditiously the delay could jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a physician with knowledge of the Claimant’s medical condition, would subject the Claimant to *severe pain* that cannot be adequately managed without the care or treatment that is the subject of the claim. The “applicable period” for an urgent care claim is no longer than

(b) General Authority

The Plan Administrator will have all the powers necessary or appropriate to carry out its duties, including the discretionary authority to interpret the provisions of the Plan and the facts and circumstances of claims for benefits, and to decide questions of fact related thereto. Any interpretation or construction of or action by the Plan Administrator with respect to the Plan and its administration will be conclusive and binding upon all parties and persons affected hereby, subject to the exclusive appeal procedure set forth in Sections 5.7 and 5.8.

5.3 Forms

All forms and other communications from any Covered Person or other person to the Plan Administrator required or permitted under the Plan will be in the form prescribed from time to time by the Plan Administrator, will be mailed first-class mail or delivered to the location specified by the Plan Administrator, will be deemed to have been given and delivered to the location specified by the Plan Administrator, and will be deemed to have been given and delivered only upon actual receipt thereof. Each Covered Person will file on a form such pertinent information as the Plan Administrator may specify. However, to the extent the terms of a Component Document provide for different or contrary rules in this regard, and such terms are permitted by law, the terms of the Component Document will control.

5.4 Examination of Documents

The Plan Administrator will make available to each Covered Person or beneficiary this Plan document, including the Appendices and Component Documents, for examination at reasonable times during normal business hours. In the event a Covered Person or beneficiary requests copies of documents, the Plan Administrator may charge a reasonable amount to cover the cost of furnishing such documents.

5.5 No Assets

Notwithstanding any Plan provision to the contrary, no assets will be segregated for the purposes of providing benefits under the Plan unless a separate trust has been established for the Plan. The Employer will pay benefits under this Plan out of its general assets, to the extent such benefits are not paid under the terms of insurance contracts.

5.6 Reports

The Plan Administrator will file or cause to be filed all annual reports, returns, and financial and other statements required by a federal or state statute, agency or authority within the time prescribed by law or regulation for filing said documents; and to furnish such reports, statements or other documents to such Covered Persons and beneficiaries as required by federal or state statute or regulation, within the time prescribed for furnishing such documents.

**ARTICLE V**  
**ADMINISTRATION**

5.1 Plan Administrator

The Employer is the Plan Administrator of this Plan. The Employer may delegate some or all of its duties and authority as Plan Administrator to one or more Employees, to a committee appointed by the Employer, to a third-party claims administrator or such other persons as the Plan Administrator deems appropriate. The Plan Administrator may delegate duties and authority with respect to the different Component Programs to different persons with respect to each Component Program.

5.2 Duties and Authority of Plan Administrator

Except to the extent an insurance company, under the terms of a Component Document, retains for itself or any other third-party (other than the Employer) the duties and responsibilities described below, the following duties and responsibilities will be the Employer's, as the Plan Administrator:

(a) Administrative Duties

The Plan Administrator will administer the Plan consistent with the nondiscrimination rules described later in this Article, for the exclusive purpose of providing benefits to Covered Persons and their beneficiaries. The Plan Administrator will perform all such duties as are necessary to supervise the administration of the Plan and to control its operation in accordance with the terms thereof, including, but not limited to, the following:

- (i) make and enforce such rules and regulations as it will deem necessary or proper for the efficient administration of the Plan;
- (ii) interpret the provisions of the Plan and determine any question arising under the Plan, or in connection with the administration or operation thereof, including questions of fact;
- (iii) determine all considerations affecting the eligibility of any individual to be or become a Covered Person;
- (iv) determine eligibility for and amount of benefits for any Covered Person;
- (v) authorize and direct all disbursements of benefits under the Plan;
- (vi) authorize the recovery of benefit payments made in error; and
- (vii) delegate and allocate, specific responsibilities, obligations and duties imposed by the Plan, to one or more employees, officers or such other persons as the Plan Administrator deems appropriate.

## ARTICLE IV

### FUNDING

#### 4.1 Contributions

The benefits described in Article III will be funded by Employer contributions or Employee contributions, or a combination thereof, as determined from time to time by the Employer. Contributions will be paid to an insurance carrier or other third-party administrator or, with respect to a self-funded, self-administered benefit, amounts will be paid directly to or on behalf of a Covered Person.

If an insurer, health maintenance organization, pharmacy benefit manager or other party pays any rebate (including any medical loss ratio rebate pursuant to the Patient Protection and Affordable Care Act of 2010), allowance, credit, or other amount with respect to the Plan or an insurance policy relating to a Component Document (a "Recovery"), whether such Recovery be paid in cash or effected as a credit against future premium or similar payments in the current or ensuing year, the Recovery amount will not be an asset of the Plan, but instead will be retained by the Employer as part of the Employer's general assets, except as provided below or as otherwise may be required by law. Therefore, a Recovery will not reduce or offset contributions or other amounts paid by Employees (or Dependents) for coverage under the Plan and will not otherwise be shared with Employees (or Dependents). If a Recovery exceeds the total amounts paid by the Employer for medical coverage under the Plan for the relevant period, the excess amount may not be retained by the Employer but instead will be treated as an asset of the Plan to the extent required by applicable law.

#### 4.2 Employee Contributions

Any Employee contributions may be deducted from an Eligible Employee's wages on a pre-tax basis (or after-tax basis if permitted by the Employer) and will be subject to the policies of the Employer and the terms and conditions of the particular Component Program(s) and any flexible benefits program maintained by the Employer pursuant to Section 125 of the Code, and will be forwarded by the Employer to an insurance carrier or other third-party administrator or, with respect to benefits that are paid directly by the Employer, amounts will be collected by the Employer and paid directly to or on behalf of a Covered Person.

With respect to self-insured benefits provided under the Plan, contributions from a Covered Person will be deemed to be applied first to the payment of benefits. The intent of this provision is to establish that, in a case where such contributions from all Covered Persons do not exceed the amount of self-insured benefits paid under the Plan, any administrative expenses related to the self-insured benefits will be deemed paid other than from contributions from Covered Persons.

## ARTICLE III

### BENEFITS

#### 3.1 Benefits Incorporated by Reference

Each Covered Person may elect to receive coverage under the benefits listed below, subject to any additional eligibility conditions provided under the applicable Component Document. The terms, conditions and limitations of benefits offered under this Plan are contained in the applicable Component Documents referenced in the Appendices and which are incorporated herein in full, as amended from time to time. The benefits and the method of providing them may change from time to time and will be reflected in the applicable Component Documents.

The benefits are:

- Medical;
- Dental;
- Vision;
- Voluntary Long Term Disability
- Voluntary Short Term Disability;
- Group Term Life;
- Voluntary Term Life;
- Voluntary Dependent Term Life;
- Universal Life (Permanent Life);
- AD&D;
- Voluntary AD&D;
- Accident;
- Worksite Critical Illness (includes Cancer)

(b) FMLA

Notwithstanding any other Plan provision providing for an earlier termination of coverage, in the event participation in a health care benefit offered through this Plan would terminate due to the Eligible Employee taking a leave of absence pursuant to the FMLA, eligibility for such benefit will be continued for the lesser of: the period of the leave or the maximum period of leave required under the FMLA; provided, however, other provisions of this Plan or the Employer's employment policies may provide for more generous continued eligibility. Coverage will continue only as long as any required Employee contributions are timely made. Employees on leave must make the same contribution as is required for active Employees. Coverage under other welfare benefits (other than health benefits) will continue or terminate during a period of FMLA leave to the same extent as such benefits continue or terminate during periods of leave under similar circumstances (that is, paid or unpaid leave, as the case may be) that is not FMLA leave.

(c) USERRA

Notwithstanding any other Plan provision regarding termination of coverage, in the event participation in health benefits offered through this Plan would terminate due to the Eligible Employee taking a USERRA leave of absence, such benefits will be continued for the lesser of: the period of leave or 24 months. Provided, however, coverage will continue only as long as any required Employee contributions are timely made. Employees on a USERRA leave of less than 31 days must make the same contribution as is required for active Employees; Employees on a USERRA leave of 31 days or longer must pay up to 102% of the full cost (Employee and Employer contributions) of coverage, as determined by the Plan Administrator.

(d) State Mandated Continuation Coverage Rights

In addition to the continuation coverage rights discussed above, some states and localities provide additional continuation coverage rights, which the Plan will comply with to the extent applicable.

terminate when the person is no longer covered for a benefit provided by any Component Document.

Notwithstanding the foregoing, and unless expressly provided to the contrary in a Component Document, coverage of any person under a Component Program may be terminated where the Plan Administrator determines that the person is ineligible for coverage; that enrollment was obtained, or benefits claimed or provided, pursuant at least in part to a misrepresentation pertaining to such person; that the person failed to supply information reasonably requested by the Plan Administrator; that premiums were not timely paid by the person or on the person's behalf; that the person failed to assist the Plan in its efforts to enforce its subrogation or reimbursement rights; or for any other reason where the Plan Administrator deems disenrollment is appropriate on account of the actions or inactions of the person (or any other person who acts or fails to act on behalf of the person). Where a Dependent is disenrolled due to such conduct, the Plan Administrator may in its discretion disenroll the Employee and/or one or more of the Employee's other Dependents where it appears such person(s) were complicit in the misrepresentation. Where an Employee is disenrolled due to such conduct, however, all enrolled Dependents will also be disenrolled.

Where coverage is terminated pursuant to the preceding paragraph, it may be terminated prospectively, and retroactively if the Plan Administrator determines that premiums were not timely paid or that the person was ineligible for coverage (coverage may be terminated retroactively to the date of (as applicable) the action giving rise to the termination or, where termination is due to ineligibility or failure to timely pay premium, to the date of the person's enrollment or, if later, the date the person became ineligible; provided, however, that with respect to Component Programs subject to the Patient Protection and Affordable Care Act of 2010, coverage will be terminated retroactively only in the event of fraud or material misrepresentation (both of which are hereby expressly prohibited by this Plan), and upon appropriate notice to the person as provided under that Act and regulations issued thereunder, or in the event of a failure to timely pay required premiums or contributions.

## 2.4 Continuation Coverage Rights

### (a) Health Care Coverages

Certain health care coverages under this Plan may be subject to coverage continuation rights under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), or similar state or federal law. Where that is the case, such coverage rights are described in the applicable Component Documents. A former Covered Person who is eligible to, and elects to, continue coverage under the applicable coverage continuation law, may continue to participate in this Plan to the extent provided under the coverage continuation law.

**ARTICLE II**  
**PARTICIPATION**

2.1 Eligibility and Enrollment

(a) Eligibility

Any person who is an Eligible Employee or Dependent under a Component Document will be considered a Covered Person in the Plan on the date such person, under the terms of such Component Document, acquires coverage for the benefit(s) described in such Component Document; in no event may an Eligible Employee or Dependent participate in this Plan with respect to a particular benefit provided under a Component Document until the date specified in such Component Document. Appendix IV reflects a *summary* of the eligibility rules that apply under the various Component Documents and benefit programs reflected in those documents. Other eligibility rules may be reflected in the Component Documents themselves, or other documents.

(b) Enrollment

An Eligible Employee may elect participation in the Plan, for himself and for any eligible Dependent(s), with respect to any or all benefits described in Article III with respect to which the Eligible Employee and/or Dependent(s), as the case may be, are eligible for coverage under the terms of the applicable Component Document(s), by completing the appropriate enrollment forms when the Eligible Employee and/or Dependent, as the case may be, first becomes eligible to participate. If an Eligible Employee (on behalf of himself and/or an eligible Dependent) does not elect to participate (or elects to participate only with respect to some, but not all, benefits) when first eligible, he may not elect to participate (or elect to participate in those health benefits not selected) until the beginning of the next Plan Year, subject to Section 2.2 and any change in enrollment rules provided under a Component Document, such as a cafeteria plan under Section 125 of the Code.

2.2 Compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

The Plan will comply with the special enrollment and nondiscrimination provisions of HIPAA, with respect to those benefits subject to HIPAA. If a Component Benefit subject to the HIPAA portability rules, it will not establish a rule for eligibility or set any premium or contribution rate based on whether the Employee is actively at work (including whether the Employee is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the Component Benefit, as being actively at work, as described in the HIPAA portability rules. See also Articles IX and X.

2.3 Termination of Participation

Participation in a benefit provided under a Component Document will terminate as provided in such Component Document. Participation by a person in this Plan will

### Participating Non-Controlled Group Employer

“Participating Non-Controlled Group Employer” means an Employer that is not an Affiliated Employer and participates in this Plan for the benefit of its Eligible Employees, pursuant to approval of such participation by the Plan Sponsor. Participating Non-Controlled Group Employers must execute a written Participation Agreement provided by the Plan Sponsor, in order to become a Participating Non-Controlled Group Employer. Any Participating Non-Controlled Group Employers participating in the Plan are listed in Appendix II.

### Plan

“Plan” means this Prime, Inc. Employee Benefit Plan, as amended from time to time.

### Plan Administrator

“Plan Administrator” means the person or entity authorized to administer the Plan pursuant to Article V. If the Employer does not appoint a Plan Administrator, the Plan Administrator is the Employer.

### Plan Sponsor

“Plan Sponsor” means New Prime, Inc. or any successor in interest.

### Plan Year

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

### USERRA

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and including all regulations issued under that Act.

### Eligible Employee

“Eligible Employee” means any Employee who meets the eligibility requirements under a Component Document. As described in Appendix IV or a Component Document, an Eligible Employee also includes proprietors, partners, corporate officers and directors, and retirees whether or not they are compensated by salary or wages. An Eligible Employee is an Eligible Employee only to the extent of, and only with respect to participation in, those portions of this Plan with respect to which he meets the eligibility requirements of the applicable Component Document. See Appendix IV for a summary of eligibility rules.

### Employee

“Employee” means any individual who is employed by an Employer, but (unless specifically included as an “Employee” under a Component Document) does not include any of the following:

- (a) Persons classified and treated by an Employer as independent contractors; if someone so classified and treated is subsequently determined by the Employer or any governmental agency or court not to be an independent contractor, such person will not be considered an Employee until the day after the final determination that such person is not an independent contractor; and
- (b) Nonresident aliens who receive no United States source income from an Employer.

In the event a person listed in one or more subsections above is specifically included as an “Employee” under a Component Document, he will be considered an Employee under this Plan only with respect to the benefit described within such Component Document, and not necessarily with respect to other benefits hereunder, described in other Component Documents.

### Employer

“Employer” means the Plan Sponsor, with respect to its Eligible Employees, and any Affiliated Employers or other Participating Non-Controlled Group Employers that are approved by the Plan Sponsor, to participate in this Plan, with respect to their Eligible Employees; provided, however, that for purposes of Sections 5.1 and 5.2, the right to amend or terminate the Plan, to determine whether another employer may be a Participating Non-Controlled Group Employer, or to perform other settlor-type functions, “Employer” means solely the Plan Sponsor.

### ERISA

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended, and including all regulations issued under that Act.

### FMLA

“FMLA” means the Family and Medical Leave Act of 1993, as amended, and including all regulations issued under that Act.

## ARTICLE I

### DEFINITIONS

The following terms, when used in this Plan, will have the following meaning, unless a different meaning is clearly required by the context. Capitalized terms are used throughout the Plan for terms defined by this and other sections.

#### Affiliated Employer

“Affiliated Employer” means any entity that is affiliated with the Employer or any entity that is part of a group of entities that includes the Employer and constitutes: (a) a controlled group of corporations (as defined in Section 414(b) of the Code); (b) a group of trades or businesses, whether or not incorporated, under common control (as defined in Section 414(c) of the Code); (c) an affiliated service group within the meaning of Section 414(m); or (d) any other entity required to be aggregated with the Employer pursuant to regulations under 414(o) of the Code. Any Affiliated Employers participating in the Plan are listed in Appendix II.

#### Appendix

“Appendix” or “Appendices” means each of the appendices to the Plan. Each Appendix and any document included or incorporated therein will be considered a part of the Plan and may be amended by the Employer at any time for any reason without consent of any person except as otherwise provided by law.

#### Code

“Code” means the Internal Revenue Code of 1986, as amended, and including all regulations issued under that law.

#### Component Document and Component Program

“Component Document” means a written document identified in the Appendices and incorporated herein by reference. “Component Program” means the program of benefits described in a Component Document.

#### Covered Person

“Covered Person” means an Eligible Employee or eligible Dependent who elects coverage under the Plan and has not for any reason become ineligible to participate in the Plan.

#### Dependent

A person is a “Dependent” of an Employee with respect to a benefit provided hereunder if such person is classified as a “Dependent” under the Component Document that describes such benefit and the classes of persons eligible therefore.

## INTRODUCTION

THIS EMPLOYEE BENEFIT PLAN is formally known as the Prime, Inc. Employee Benefit Plan (the "Plan").

The purpose of the Plan is to consolidate the multiple insured and/or self-insured health and welfare benefit plans sponsored and maintained by the Employer into a single, comprehensive health and welfare plan, for ease of administration and reporting. This type of Plan is sometimes referred to as a "wrap" or "umbrella" plan. While this document is designed to accomplish such consolidation, it is not the only document comprising the Plan. Rather, the entire Plan document is actually a series of documents, consisting of this document plus the various contracts and/or booklets that describe the specific benefits, rights and features under the various welfare benefit programs that are consolidated in this Plan. Together, this and such other documents comprise both the official "Plan document" and the "Summary Plan Description."

This Plan is effective January 1, 2014, provided that certain provisions may have a different effective date as described elsewhere in the Plan, and amends and restates the existing comprehensive health and welfare plan maintained by the Plan Sponsor in its entirety.

This Plan will be maintained for the exclusive purpose of providing benefits to covered Employees and, where applicable, their Dependents, and is intended to comply with all applicable laws, including the Internal Revenue Code of 1986, as amended, and the Employee Retirement Income Security Act of 1974, as amended.

PRIME, INC. EMPLOYEE BENEFIT PLAN & SUMMARY PLAN DESCRIPTION

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