DENSO
Health & Welfare Plan

Plan Document and Summary Plan Description
(for the Self-Funded Benefit Programs)

Summary Plan Description
(for the Insured Benefit Programs)

Plan No. 526

Although this booklet references DENSO International America, Inc., the benefits and related effective dates, provisions, conditions, limitations and exclusions are identical for the following DENSO Group Companies:

- DENSO Manufacturing Arkansas, Inc. (DMAR)
- DENSO Manufacturing Athens Tennessee, Inc. (DMAT)
- DENSO Manufacturing Michigan, Inc. (DMMI)
- DENSO Manufacturing Tennessee, Inc. (DMTN)
- DENSO Products and Services Americas, Inc. (DPAM)
- DENSO Manufacturing North Carolina, Inc. (DMNC)

Amended and Restated as of January 1, 2020

DENSO
Crafting the Core

TABLE OF CONTENTS

INTRODUCTION

DENSO INTERNATIONAL AMERICA, INC. (the "**Sponsoring Company**") amends and restates the DENSO HEALTH & WELFARE PLAN (the "**Plan**"), effective January 1, 2020. The Plan is sponsored and maintained for the benefit of the Company's eligible employees and their eligible dependents. For purposes of this document, "**Company**" means the Sponsoring Company and any other employers related to the Sponsoring Company that have adopted the Plan with the consent of the Sponsoring Company and are listed on the Participating Companies Chart at the end of this document ("**Participating Companies**").

The Plan allows you to choose benefits from among the following benefit programs (the "**Benefit Programs**"):

- a "**Medical Program**" that provides comprehensive major medical, hospitalization, prescription drug, mental health and substance abuse benefits, as well as disease management benefits (a reference to the "Medical Program" throughout this document includes all of these services unless otherwise indicated);

- a "**Dental Program**" that provides benefits to pay for maintenance and treatment services for teeth and gums;

- a "**Vision Program**" that provides benefits including eye examinations, lenses and/or frames;

- a "**Short-Term Disability Program**" (the "**STD Program**") that provides income replacement benefits for a limited period of time if you become disabled. The Company pays for a basic STD benefit under this Program.

- a "**Long-Term Disability Program**" (the "**LTD Program**") that offers income replacement benefits for a period of time if you become totally disabled;

- a "**Life/Accidental Death and Dismemberment Program**" (the "**Life/AD&D Program**") that provides benefits for you or your beneficiary in the event of your death, paralysis or loss of limb due to an accident;

- a **"Voluntary Benefits Program"** that allows you to purchase critical illness,accident and hospital indemnity coverage;

- an "**Employee Assistance Program**" (the "**EAP**") that provides you with counseling to help with work, family, and other personal matters;

- a "**Pre-Tax Payment Program**" that allows you to pay your share of the cost of Benefit Programs with pre-tax dollars;

- a "**Day Care Flexible Spending Account Program**" (the "**Day Care FSA Program**") that allows you to pay for Eligible Dependent Care Expenses on a pre-tax basis up to an annual maximum of $5,000 ($2,500 if married and filing separately);

- a "**Health Care Flexible Spending Account Program**" (the "**Health Care FSA Program**") that allows you to pay for unreimbursed medical expenses on a pre-tax basis;

- a "**Health Savings Account Contributions Program**" (the "**HSA Program**") that allows you to contribute on a pre-tax basis to a Health Savings Account if you enroll in the Plan's high deductible health plan option;

- a "**Business Travel Accident Insurance Program**" that offers insurance for unexpected injuries or illness that you may incur while traveling on Company business;

- an "**On-Site Medical Program**" that offers you and your Covered Dependents convenient access to medical and/or pharmacy services at select Family Health Center locations; and

- a "**Healthy Horizons Program**" that provides confidential education, tools, and positive support to understand and make continuous improvements to your health so you can kaizen your life and achieve your personal goals.

Some of the benefits are insured, which means the Company pays premiums to insurance companies that then pay for the benefits under insurance policies or contracts. Other Benefit Programs are Self-funded. "**Self-funded**" means the benefits are paid from the Company's general assets and are not provided through an insurance contract. The Benefit Program & On-Site Medical Health Centers Information Chart at the end of this document indicates each Benefit Program's type of funding.

For each insured Benefit Program:

- There is an insurance contract or policy that together with this document serves as the official Plan document for that Benefit Program. If a conflict arises between the terms of this document and the insurance contract or policy, the eligibility provisions in this document will control and all other terms of the insurance contract or policy will control.

- The insurer also prepares one or more booklets, summaries, and/or certificates that describe the benefits available ("**Booklets**"). Those Booklets, together with this document, are the Summary Plan Description ("**SPD**") for the insured Benefit Programs. If a conflict arises between the terms of this document and a Booklet, the eligibility provisions in this document will control and all other terms of the Booklet will control.

This document and the accompanying Benefit Program Booklets describe the provisions of the Plan as of January 1, 2020, unless otherwise stated herein. The provisions of this Plan apply uniformly to all Participants. Please read these documents carefully and keep them with your personal records for future reference. Throughout this document, capitalized words have specific meanings and are defined terms. Where a term is defined, it also appears in bold print and in quotes. For your convenience, an Index of Defined Terms appears at the end of this SPD with page references to each defined term.

If you have any questions about a Benefit Program or the Plan in general, please contact your local HR/Benefits representative.

OBTAINING AND CHANGING COVERAGES

ELIGIBILITY

Associate Eligibility

Generally, you are eligible to participate in each Benefit Program on your date of hire if you are classified by the Company as an Associate of the Company who is regularly scheduled to work 20 or more hours per week.

Your participation will generally begin in accordance with the following schedule:

Benefit Program	When Participation Begins
Life and AD&D Program – basic coverage	On date of hire
Employee Assistance Program (EAP)	
Business Travel Accident Insurance Program	
Healthy Horizons Program	
On-Site Medical Program	
Medical Program	On the 1st of the month following 30 days date of hire
Dental Program	
Vision Program	
Health Care Flexible Spending Account (FSA)	
Day Care Flexible Spending Account (FSA)	
HSA Program	
Life and AD&D Program – optional coverage	
Voluntary Benefits Program*	
Pre-Tax Payment Program	
Short-Term Disability Program	After 6 months from date of hire
Long-Term Disability Program	

Only individuals classified as Associates of the Company who are regularly scheduled to work 20 or more hours per week may participate in the Benefits Programs. You are ***not*** eligible to participate in this Plan if the Company has classified you in any of the following categories, even if it is later determined that the classification is incorrect: an individual covered by a collective bargaining agreement; a leased employee; an employee of an entity that is not a Participating Company; a seasonal employee or an intern; or any other classification other than Associate of the Company.

Notwithstanding the foregoing, interns and co-op employees on DENSO payroll are eligible to participate in the OpenRoad Medical Benefit Plan Option and the EAP. Interns and co-op employees on DENSO payroll are not eligible for any other benefit under the Plan, including but not limited to the Healthy Horizons Benefit Program, the Pre-Tax Payment Program, or an employer contribution under the HSA Program.

Expatriate Associate Eligibility
Expatriate employees are eligible to participate in those benefits in which the Company or a non-United States based affiliated employer authorizes you to participate if DIAM or the non-United States based affiliated employer:

- classifies you as a member of a select group of professionals or managerial expatriate associates ("**Expatriate Associate**"), and

- specifically notifies you of your eligibility to Participate.

If you are an Expatriate Associate and are covered under this Plan as well as under a welfare benefit program of a foreign affiliate, then medical, dental or vision benefits under this Plan will only be provided if such benefit under the Plan is greater than the benefit available under the other welfare benefit program, and the claim under this Plan does not duplicate coverage for such claim provided under the other welfare benefit program.

For purposes of these provisions, Expatriate Associates and their covered Spouses and Dependents will be treated as if their claims were incurred in-network despite the fact that such claim was incurred outside of the United States. Additionally, Expatriate Associates and their covered Spouses and Dependents who are prescribed long-term maintenance drugs will be permitted to fill such prescriptions in amounts sufficient to provide a supply for the lesser of one year or the duration of the period during which they are assigned to work outside of the United States, regardless of any 31 or 90 day supply prescription coverage limitations that apply under the Plan. Existing deductible and/or co-pays will apply.

All claims for benefits under this subsection must be submitted directly to the local Human Resources representative of a Participating Company, and cannot be processed directly by the Claims Administrator.

If you are covered under this Plan at the time you become an Expatriate Associate, your life insurance coverage will continue and you may elect to continue your voluntary life insurance coverage under this Plan, if any, during the term of your status as an Expatriate Associate.

Special Rules for Canadian Associates
If you are an eligible Associate of the Company and a full-time resident of Canada, you may elect to participate either in this Plan or in the health and welfare benefit program sponsored by DMCN. The benefits and terms of the DMCN program will be explained to you in a separate communication. If you make the election to participate in the DMCN program, the DMCN program coverage will be provided in lieu of all other coverages under this Plan, with one exception: you will be eligible under this Plan for the Pre-Tax Payment benefit, which generally allows you to pay through payroll deduction your portion of any premiums owing under the DMCN program on a pre-tax basis (meaning before certain federal income taxes are withheld). Once made, the election to participate in the DMCN program in lieu of other coverage under this Plan cannot be revoked during the Plan year. Your eligibility and participation in the DMCN program will be determined solely under the terms of the DMCN program.

A Canadian Associate who elects to participate in this Plan will not be eligible to participate in the Health Savings Account Contributions Program.

Service Credit For Employment With Affiliates
For any employee of DENSO Air Systems Michigan, Inc. ("ASMI") who upon termination of employment with ASMI becomes an employee of the Company and meets the Associate Eligibility rules above, the Company will credit the employee's employment service with ASMI towards any applicable waiting period or for any other purpose under the Plan that takes employment service into account. Further, to the extent possible, the Company will credit the former ASMI employee with his or her medical claims experience under the ASMI plan for purposes of determining claims experience under this Plan for the remainder of the Plan Year in which the employee is hired by the Company.

DENSO Manufacturing North Carolina, Inc. ("DMNC") will become a Participating Company in the Plan on January 1, 2020. For those DMNC employees who meet the Associate Eligibility rules above, the Company will credit their employment service with DMNC towards any applicable waiting period or for any other purpose under the Plan that takes employment service into account.

Dependent Eligibility
Members of your family who are dependent on you may also be eligible for coverage under the Plan. The Plan Administrator may require you to show proof that a dependent meets the eligibility criteria. You must notify the Plan Administrator on or before the 30th day following the date of any status change that would result in a dependent or Domestic Partner no longer being an Eligible Dependent (for example, your Spouse in the event of a divorce). The Plan has a right to recover from you any payments made by the Plan on behalf of an individual who is not an Eligible Dependent (*Refer to Overpayments*).

An "**Eligible Dependent**" is:

- your legal spouse ("**Spouse**");

- your Company-registered Domestic Partner if you are a resident of the State of California. Please note that the IRS has ruled that a Domestic Partner is not a Spouse, and the Plan must comply with this ruling for tax and reporting purposes;

- For the Medical Program:

    - your Child or your Spouse's Child through the end of the month in which he or she turns age 26, regardless of student or marital status, financial dependence or where they reside;

    - a Child who must be provided health coverage under the Plan as required by a Qualified Medical Child Support Order; and

    - an unmarried Child, regardless of age, provided that he has been continuously incapable of self-support because of a mental or physical handicap that existed prior to age 26. Proof of such handicap must be submitted to the Claims Administrator within 31 days after the dependent child attains age 26.

- For all other Benefit Program options: a Child shall be defined in the relevant Booklets describing that Benefit Program.

For purposes of the group health plans, "**Child**" includes a natural biological child, step-child, legally adopted child, child placed with you in anticipation of the child being adopted by you, or child by virtue of legal guardianship or legal custody. Child also includes an individual who is determined to be an alternate recipient under a qualified medical child support order ("**QMCSO**").

Your Child will be eligible for coverage even if the Child is born out of wedlock, is not claimed by you as a dependent for federal income tax purposes, does not reside with you, or is married (unless specifically excluded by an individual Benefit Program).

A "**Covered Dependent**" is an Eligible Dependent covered under the Plan.

Unless specifically excluded by an Individual Benefit Program, this Plan allows your family members to be covered even if they may not be "qualified children" or "qualified relatives" under Code Section 152 and, thus, could not be declared as a dependent on your federal income tax returns.

"**Domestic Partner**" means an individual of the same or opposite sex with whom you have established a domestic partnership in the State of California. Both persons must:

- not be so closely related that marriage would otherwise be prohibited in the State of California;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract;
- be financially interdependent; and
- file a valid Declaration of Domestic Partnership with the California Secretary of State, and a copy of the filing must be provided.

For opposite-gender couples, one partner must be at least age 62 and at least one partner must be eligible for Social Security Benefits. Please contact your local HR/Benefits representative for more details regarding enrolling a Domestic Partner.

If you and your Domestic Partner dissolve your Domestic Partnership, you must file a Declaration of Termination of Domestic Partnership Form with your local HR/Benefits representative within 30 days from the termination of your domestic partnership, and you must wait at least *six* months to add another Domestic Partner. Domestic Partners are ***not*** entitled to COBRA Continuation

Coverage, though the Company may provide continuation coverage similar to COBRA Continuation Coverage.

Domestic Partner's Dependents
You may also cover your Domestic Partner's children who meet the definition of "Child" under this Plan. However, your Domestic Partner's children who do not qualify as your dependent under Code Section 105(b) will not be eligible to be covered under the Health Care FSA Program.

Imputed Income
The value of coverage provided to your Domestic Partner or your Domestic Partner's dependents under any of the Plan's Benefit Programs will be taxable income to you, unless your Domestic Partner or your Domestic Partner's dependents meet the requirements for being your dependent under Code Section 105(b).

PARTICIPATION

To start participating in the Plan, you need to fill out online enrollment forms ("**Enrollment Forms**") as directed by the Plan Administrator. On the Enrollment Forms, you elect the Benefit Programs in which you wish to participate and authorize the Company to reduce your pay in accordance with those elections. Only you, as an Associate, may fill out the Enrollment Forms or make Benefit Program elections. If you have properly enrolled in the Plan, you are a "**Participant**."

An Eligible Dependent who is properly enrolled in a Benefit Program is a "**Covered Dependent**."

Initial Enrollment Period
As a newly hired Associate, you will participate in the Benefit Programs on the first day of employment, as long as you complete and return the Enrollment Forms as directed by the Plan Administrator on or before the 30th day following that date ("**Initial Enrollment Period**").

Your election will be effective from your date of hire and your contribution for this coverage will be withheld from the compensation you earn after you complete your enrollment. Elections during your Initial Enrollment Period are irrevocable until the next Open Enrollment Period, unless you are eligible to enroll during a Special Enrollment Period or you experience a Family Status Change Event.

If you fail to complete your enrollment on or before the 30th day immediately following your date of hire, you will be automatically enrolled in Associate-only level of coverage in the Medical (including Rx and Behavioral Health), Dental, STD, LTD, Life/AD&D, EAP, Pre-Tax Payment and Business Travel Accident Programs, and will be able to change your coverage options only at the next Open Enrollment Period, Special Enrollment Period, or if you experience a Family Status Change Event.

Open Enrollment Period
Each year the Company establishes an "**Open Enrollment Period**," which is usually toward the end of the Plan Year. During the Open Enrollment Period, you can make new benefit choices and elections for the upcoming Plan Year.

To change your elections under the Plan, or enroll for the first time during an Open Enrollment Period if you failed to do so during your Initial Enrollment Period or during prior Open Enrollment Periods, you must enroll online before the Open Enrollment Period ends. The "**Period of Coverage"** under the Plan is a 12-month period, beginning on the first day of the Plan Year.

The choices you make during the Open Enrollment Period will be effective on the first day of the upcoming Plan Year, and once the new Plan Year has started, your choices are irrevocable for that Period of Coverage and will remain in effect without any changes permitted through the remainder of the Plan Year unless you experience a Family Status Change Event or are entitled to a Special Enrollment Period, except that you may change your contributions under the Health Savings Account Contribution Program at any time on a prospective basis.

After the open enrollment period ends, changes to your elections may be permitted prior to December 15th, but only in limited circumstances. In addition to permitting changes to your elections pursuant to a Special Enrollment Period or a Family Status Change Event, election changes may be permitted before the coverage takes effect if:

- There were internal errors or omissions on the part of the Company that affected your ability to make timely elections;

- You are married to another DENSO Associate and the two of you have inappropriately enrolled in duplicate coverage;

- You enrolled in either of the Flexible Spending Accounts and have reason to change a Flexible Spending Account annual election;

- You review the eligibility of your Dependents and have reason to enroll or un-enroll a Dependent; or

- Your Spouse's employer holds open enrollment after the end of the Plan's open enrollment period, which adversely affected enrollment of you and/or your Spouse or Dependents in the Plan.

If you are on a leave of absence during an Open Enrollment Period (include a leave under the Family and Medical Leave Act of 1993), you will be allowed to make an election during the Open Enrollment Period just like any active employee.

Special Enrollment Period

A "**Special Enrollment Period**" is a period of enrollment other than the annual Open Enrollment Period or an enrollment period for newly eligible Associates during which you may elect to enroll in the Medical, Dental, Vision, EAP and Health Care FSA Programs. You and your Eligible Dependents may enroll during a Special Enrollment Period in the following circumstances:

Enrollment Of Newly Eligible Dependents

If you gain a new Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, the following individuals may be enrolled in the Plan if they are not currently enrolled: (1) you; (2) your Spouse; and (3) any new Dependents. You must request enrollment, and provide any required supporting documentation, in accordance with the procedures and timeframes described in the section titled "Procedures For Changing Elections Mid-Year" below.

Coverage will begin on the date of the birth, adoption, or placement for adoption or marriage.

Loss Of Other Coverage

If you or your Eligible Dependents did not enroll in this Plan previously because you were covered under another group health plan or had other health insurance coverage, you and your Eligible Dependents may enroll in the Plan during a Special Enrollment Period if the following requirements are met:

- You declined coverage when it was previously offered because you or your Eligible Dependents were covered under another group health plan or had other health insurance coverage; and
    - The other coverage was COBRA Continuation Coverage and it was exhausted; or
    - The other coverage ended because
        - you lost eligibility (including as a result of divorce, legal separation, loss of dependent status, death, termination, or reduction in hours of employment, or because you no longer live or work in the other health plan service area;
        - the other coverage no longer offers any benefits to a class of similarly situated individuals; or
        - employer contributions to the other coverage were terminated.

You must request enrollment within 30 days after the other coverage ended. You must provide satisfactory proof of the loss of other coverage if requested.

An individual who loses coverage for the following reasons is <u>not</u> eligible for a Special Enrollment Period:

- The individual did not pay premiums on a timely basis.
- The individual chose to drop coverage for any reason, including an increase in premium or change in benefits.
- The individual's coverage was terminated for cause, such as a fraudulent claim or intentional misrepresentation of a material fact in connection with the Plan.

Enrollment due to loss of other coverage will be effective as of the date the Company receives notification or, if later, the date you will lose the other coverage.

Medicaid/Children's Health Insurance Program Changes

If you, your Spouse, or other Eligible Dependents are eligible for, but not enrolled in this Plan, you are entitled to a Special Enrollment Period to elect coverage under the Plan if:

- Your coverage or the coverage of your Spouse or other Eligible Dependent under a Medicaid plan or state Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility and you request coverage under this Plan no later than 60 days after the date the Medicaid or CHIP coverage terminates; or

- You, your Spouse or other Eligible Dependent become eligible for a premium assistance subsidy in this Plan under a Medicaid plan or state CHIP (including any waiver or demonstration project) and you request coverage under this Plan no later than 60 days after the date you are determined to be eligible for such assistance.

Failure To Timely Enroll
If you do not complete the enrollment process during an Open Enrollment Period or a Special Enrollment Period, you will be deemed to have declined coverage in the Benefit Programs, except as described below.

If you do not complete the enrollment process during the Initial Enrollment Period, you will still be enrolled automatically in the On-Site Medical Program and in Associate-only coverage in the following Benefit Programs ("**Default Elections"**):

- Medical Benefit Program (ExpressWay option);

- Dental Benefit Program (Dental Core option);

- Basic Life and AD&D Program;

- STD Benefit Program;

- LTD Benefit Program;

- Healthy Horizons Program;

- EAP; and

- Business Travel Accident Insurance Benefit Program.

If you are enrolled in the Plan and fail to complete the enrollment process during an Open Enrollment Period, your prior elections will generally renew, except that you will be deemed to have elected not to participate in the Voluntary Benefit Programs and the Day Care FSA and Health Care FSA Programs for the coming Plan Year, and you will only be able to participate in the Health Savings Account Contribution Program once you complete a new HSA contribution form for the new Plan Year. In some years, the Company may require you to affirmatively elect coverage during the Open Enrollment Period in order to have coverage in some or all Benefit Programs for the following Plan Year, and if you fail to complete the enrollment process, you will receive the Default Elections described above.

Participation During A Leave Of Absence
For any Company-approved leave, whether paid or unpaid, including leave that qualifies under the FMLA, you will be entitled during your leave to continue your coverage under the Plan at the

same coverage level in effect at the time of your leave for up to twelve (12) months (or, if later, the date any state-mandated leave period ends). After twelve (12) months, or if you do not return to work after your leave ends, your Plan coverages will terminate, subject to any applicable COBRA continuation rights.

When you return from your leave, you will be entitled to receive the same benefits as you were receiving immediately before the start of your leave, subject to the rules described in the section below titled "Participation Upon Rehire or Return From a Leave of Absence".

If you do not wish to continue all of your coverage during your leave, you must inform your local HR/Benefits representative within 7 days of your request for a leave. You will be permitted to opt out of all benefits during your leave.

If you wish to continue your benefits during your leave, and you are currently required to make Benefit Contributions, your Benefit Contributions will generally be handled as follows:

- If your leave is a paid leave (and paid by DENSO), you will continue having your compensation reduced as it was before your leave.

- If your leave is unpaid (or paid by someone other than DENSO), DENSO will pay required contributions on your behalf while you are on leave and will deduct the contributions from your pay on a pre-tax basis when you return. You authorize DENSO to automatically deduct any necessary amounts from future pay checks until the contributions DENSO paid on your behalf while you were on leave are repaid. If you fail to return to work after exhausting your leave, the Company reserves the right to recover the cost of the contributions the Company paid on your behalf while you were on leave.

- If the total amount of contributions DENSO made on your behalf while you were on leave is $100 or less, DENSO will automatically reduce your salary by the full amount of those contributions during your first payroll period upon return from leave.

- If the total amount of contributions DENSO made on your behalf while you were on leave is more than $100, DENSO will divide the total amount of those contributions by four equal payments over the next four payroll periods. If the amount of any paycheck is insufficient for the installment payment, DENSO will take the maximum amount permitted by law toward satisfaction of the amount due.

    - Upon request, you may elect to have the total amount of contributions DENSO paid on your behalf while you were on leave deducted from the first payroll period upon your return from leave.

    - If a bonus is paid to you while you are on leave, DENSO will deduct up to 50% of the bonus to pay towards any amount of the contributions DENSO paid on your behalf while you were on leave. You may request to have DENSO utilize up to 100% of your bonus to satisfy the amount you owe.

    - If a bonus is paid to you upon your return from leave, you may alternatively elect to have any amount of the contributions DENSO paid on your behalf while you

were on leave taken from the bonus payment rather than completing the installment payments described above.

Special rules apply to the Day Care FSA and Health Care FSA Programs, which are described in those sections. Also, if you participate in the Critical Illness and the Accident coverages offered through the Voluntary Benefits Program, DENSO will not contribute to these plans during your leave; instead, the insurer will bill you directly for your premiums for so long as you continue to qualify for these coverages during your leave of absence.

End Of Plan Participation
Your participation (and your Covered Dependents' participation) in the Plan and your pay period will end on the earliest of:

- your termination of employment (unless you have elected COBRA Continuation Coverage for a Benefit Program for which COBRA is available);

- a Family Status Change Event (as defined below) that leads you to revoke your participation;

- your (or your dependent's) failure to meet the eligibility requirements or conditions described in the Plan (unless you have elected COBRA Continuation Coverage for a Benefit Program for which COBRA is available);

- for the insured Benefit Programs, the date coverage under the policy ends when the group insurance policy or contract between the Company and the insurer is terminated;

- for Covered Dependents, pursuant to the terms of the Qualified Medical Child Support Order under which he or she participates in the Plan;

- the date your coverage is terminated for cause, for example, you commit or attempt to commit fraud against the Plan or you have been dishonest about a material matter affecting eligibility or benefits. ***In the case of fraud or intentional misrepresentation of a material fact, coverage may be retroactively terminated.***; or

- the Sponsoring Company terminates the Benefit Program or your Company ends its participation in the Benefit Program.

Participation Upon Rehire or Return From a Leave of Absence
If, during the same Plan Year, you terminate employment and you return to employment within 30 days or you are on an unpaid leave of absence of less than 30 days and then return to work, your elections under the Plan before your termination of employment will be automatically reinstated, and you will not have the opportunity to make a new election. If, during the same Plan Year, you terminate employment and you are rehired later than the 30th day immediately following your termination date, or you return from a paid leave of absence longer than 30 days, you can immediately reenter the Plan and may make new benefit elections for the remainder of the Plan Year. If you are rehired in a later Plan Year, you will be treated as a new hire.

Elections May Not Defer Compensation
No election that you make under the Plan or any Benefit Program available through the Plan can serve to defer compensation you have earned in one Plan Year to the next. Nevertheless, (i) compensation reductions in the final month of a Plan Year that satisfy premium obligations for coverage in the first month of the immediately following Plan Year, (ii) reimbursement for advanced payments required for orthodontia procedures extending from one Plan Year to the next, (iii) payment or reimbursement for durable medical equipment with a useful life beyond a single Plan Year, (iv) vision or dental insurance that requires a two-year coverage period, if premiums are paid annually and no part of the first year's payments go towards the second year's premiums, and (v) disability payments under a long term disability policy, if applicable, are treated as not improperly deferring compensation under this Plan.

FAMILY STATUS CHANGE EVENTS

You cannot change your benefit elections during the Plan Year outside an enrollment period, unless you experience a "**Family Status Change Event**" and the change you want to make is consistent with the Family Status Change Event.

Family Status Change Events For All Benefit Programs
You may change your Benefit Program selections if you or your Covered Dependent becomes eligible or ineligible for coverage on account of a change in:

- legal marital status (for example, marriage, divorce, legal separation, annulment);
- number of Eligible dependents (for example, birth, death, adoption, placement for adoption);
- employment status (for example, strike or lock out, termination, commencement, leave of absence, including those protected under the FMLA);
- work schedule;
- residence or worksite;
- a Covered Dependent's status (that is, a family member becomes eligible or ineligible for benefits under the Plan);
- coverage resulting from an election change made under another employer's benefit plan due to a Family Status Change Event permitted under the other employer's benefit plan ***(not available for the Day Care FSA or Health Care FSA Programs)***;
- the availability of benefit options or coverage under any of the Benefit Programs under the Plan (for example, an HMO is added to or deleted from the Medical Program) ***(not available for the Day Care FSA or Health Care FSA Programs)***;
- an election made by your Spouse or other Covered Dependent during an open enrollment period under your Spouse's or other Covered Dependent's employer's benefit plan that relates to a period that is different from the Plan Year for this Plan (for example, your

Spouse's open enrollment period is in July and your Spouse changes coverage) ***(not available for the Day Care FSA or Health Care FSA Programs)***;

- the cost of coverage during the Plan Year, but only if it is a significant increase or decrease ***(not available for the Health Care FSA and Day Care FSA Programs)***; or

- your dependent care provider or cost of dependent care (a significant increase or decrease) ***(available for the Day Care FSA Program only)***.

Special Rules For the Voluntary Benefits Program
For purposes of the Voluntary Benefits Program, you may drop or decrease your coverage at any time. If you experience a Family Status Event, you may drop your coverage entirely or remove a family member from your coverage, but you may not add coverage for yourself or a family member. Additionally, you may only add coverage under the Voluntary Benefits Program during the Open Enrollment Period.

Additional Family Status Change Events For Health Care Options
In addition to the above Family Status Change Events, you may also change elections for the Medical, Dental, Vision and Health Care FSA Programs if:

- you, your Spouse, or other Covered Dependent become eligible for continuation coverage under COBRA or USERRA;

- a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order), is entered by a court of competent jurisdiction that requires accident or health coverage for your child;

- you, your Spouse, or other Covered Dependent become enrolled under Part A, Part B, or Part D of Medicare or under Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines); or

- you, your Spouse, or other Covered Dependent become eligible for a Special Open Enrollment Period.

Additional Family Status Change Event For the Medical Program
In addition to the above Family Status Change Events, you may also change your elections under the Medical Program if you become eligible to enroll in a health plan offered through the Health Insurance Marketplace, either because of a special enrollment right or during the Marketplace's annual open enrollment period, and your new coverage under such a plan will become effective no later than the day after your coverage under this Plan ends. You will be required to certify your intent to enroll in the Marketplace coverage.

Additional Rules For the Life/AD&D Program
In addition to the above Family Status Change Events, you may also change your elections under the Life/AD&D Program if you have a change in salary. Further, you may drop or decrease any optional coverage under the Life/AD&D Program at any time.

Consistency Rule
Your election change must be consistent with the Family Status Change Event that affects your coverage under a Benefit Program. Examples:

- If your dependent care provider changes, you could not change your Medical Program elections, but you could change your elections relating to the Day Care FSA Program.

- If one of your family members no longer qualifies as a Covered Dependent, you could cancel coverage for that family member, but you could ***not*** cancel coverage for your other Covered Dependents.

- If you have single coverage and you marry, you may elect family coverage.

Some of the Family Status Change Events may allow you the option of either increasing or decreasing coverage, for example, your Spouse changing an election under his or her employer's plan allows you to increase or decrease your benefits under the Plan so long as your choice is consistent with your Spouse's election. If you are not sure the election change you would like to make is consistent with the Family Status Change Event, you should contact your local HR/Benefits representative.

Special Rule for Election Changes for HSAs
If you are making contributions to your HSA through the HSA Program, you may at any time elect to increase, decrease or entirely stop making your contributions. The change will be effective as of the next payroll period that begins after your submission of the completed election as directed by the Plan Administrator, or as soon thereafter as administratively feasible. The change will not affect your prior HSA contributions, but only contributions that you make going forward.

When you make a change to your HSA contributions, you will not be permitted to make any mid-year election changes to your other elected benefits unless you independently meet the other requirements in this section that would permit a mid-year election change.

Procedures For Changing Elections Mid-Year
If you want to change an election because of a Family Status Change Event, you must provide notification of the event and complete the required paperwork. You will be required to provide additional documentation for certain Family Status Change Events, such as a marriage certificate if you wish to add a new Spouse to your benefits coverage. You must complete the required paperwork and submit it to your local HR/Benefits representative on or before the date that is 30 calendar days after the date of the Family Status Change Event. However, if the Family Status Change Event is the birth of a baby, then you may enroll the baby in the Medical Program after this 30-day period by providing notice on or before the date that is 60 calendar days after the date of the birth.

For any election change to become effective, you must also provide any required documentation to your local HR/Benefits representative within 60 calendar days of the date of the Family Status Change Event.

Once you have provided any required documentation, the change in coverage generally will be effective as of the date you notify your local HR/Benefits representative of the Status Change

Event. If, however, the Family Status Change Event is marriage, divorce, establishment or dissolution of domestic partnership, death, birth, establishment of a legal guardianship, adoption or placement for adoption, the change in coverage will be retroactively effective to the date of the event. If one or more payroll periods have passed since the Family Status Change Event occurred, DENSO will waive any additional premiums for retroactive coverage for up to 30 calendar days from the date that the event occurred.

If you failed to properly request for a change in coverage or failed to provide any required supporting documentation by the deadlines stated above, you will have to wait until the next Open Enrollment Period, a Special Enrollment Period, or until you experience another consistent Family Status Change Event to make the change. But, if the Family Status Change Event is the birth of a baby and you provide notice of a requested change in Medical Program coverage more than 60 days but no later than six months after the date of the birth, the requested change of enrolling the baby in the Medical Program will take effect retroactively to the date of the child's birth. In this case, you must pay the premiums for this Medical Program coverage on an after-tax basis for the remainder of the Plan Year in which the baby is added. In no event will the late request be granted more than six months after the date of the child's birth.

Despite anything in this section to the contrary, a change request with respect to enrolling in and/or increasing coverage under Optional Employee Life Insurance and Optional Dependent Life Insurance must be filed on or before the date that is 30 calendar days after the date of the Family Status Change Event. If you file a request for a change in coverage with respect to Optional Employee Life Insurance and Optional Dependent Life Insurance more than 30 days after the date of the Family Status Change Event, the requested change will not take effect, and you will have to wait until the next Open Enrollment Period, a Special Enrollment Period, or until you experience another consistent Family Status Change Event to make the change.

BENEFIT PROGRAMS

MEDICAL PROGRAM

For a full description of the Medical Program benefits, please refer to the Booklet provided by the Claims Administrator listed in the Benefit Program & On-Site Medical Health Centers Information Chart.

DENTAL PROGRAM

For a description of the Dental Program benefits, please refer to the Booklet provided by the Claims Administrator listed in the Benefit Program & On-Site Medical Health Centers Information Chart.

VISION PROGRAM

For a description of the Vision Program benefits, please refer to the Booklet provided by the Insurer listed in the Benefit Program & On-Site Medical Health Centers Information Chart.

STD PROGRAM

For a description of the STD Program, please refer to the Booklet provided by the Claims Administrator listed in the Benefit Program & On-Site Medical Health Centers Information Chart.

Under the STD Program, a disability includes time missed for organ donation and related reconstructive cosmetic surgery. For Company employees residing in California, California law may provide you with additional benefits if you donate an organ or bone marrow in certain circumstances. During this leave, the Company will continue your coverage under the Company's group health plan in the same manner as if you were actively at work during the leave period. You will continue to be paid under the STD Program, and the Company will supplement your pay if necessary to comply with the law. To receive these additional benefits, you must have been employed by the Company for at least a 90-day period immediately preceding the commencement of leave. You must also provide written verification to the Company that you are an organ donor or bone marrow donor and that there is a medical necessity for the donation of the organ or bone marrow. The Company will administer these additional benefits in accordance with California's Michelle Maykin Memorial Donation Protection Act. If this law is amended, repealed, or otherwise invalidated, the rights provided in this paragraph shall be modified or rescinded accordingly.

LTD PROGRAM

For a description of the LTD Program benefits, please refer to the Booklet provided by the Insurer listed in the Benefit Program & On-Site Medical Centers Information Chart.

LIFE/AD&D PROGRAM

For a description of the Life/AD&D Program benefits, please refer to the Booklet provided by the Insurer listed in the Benefit Program & On-Site Medical Health Centers Information Chart.

VOLUNTARY BENEFITS PROGRAM

For a description of the critical illness, accident and hospital indemnity coverages available, please refer to the Booklets provided by the Insurer listed in the Benefit Program & On-Site Medical Health Centers Information Chart.

PRE-TAX PAYMENT PROGRAM

The Pre-Tax Payment Program is designed to help you pay your Benefit Contributions, on a pre-tax basis. Certain benefits available under the Plan are paid for by you with taxable income. These benefits include: Voluntary Associate Term Life, Dependent term Life, Spousal Term Life, Critical Illness and Accident coverage. Your Benefit Contributions for these benefits must be made after taxes have been deducted from your pay. Additionally, the Pre-Tax Payment Program may not be used to purchase individual health plan insurance.

Under the Pre-Tax Payment Program your taxes will be lower because certain Benefit Contributions will not be subject to federal, state, most municipal, or Social Security taxes. Because your compensation is reduced, this may reduce other benefits that are based on your compensation, such as Social Security. For most employees, these benefit reductions are fairly small, particularly compared to the tax savings. In some cases, benefits might not be reduced at all.

NOTE: Life insurance and disability benefits are calculated based on an individual's base salary without regard to 401(k), 125, etc. contributions.

Benefit Options
Under the Pre-Tax Payment Program, you have a choice under the Plan to either:

- decline to participate in the optional Benefit Programs and receive your full taxable compensation for a Plan Year through the Company's normal payroll system; or

- have a portion of your taxable compensation reduced and have the Company apply that amount to pay for your qualifying Benefit Contributions to the plan on a *pre-tax* basis.

If you choose to have your compensation reduced, this will, under current law, reduce your federal, state, most municipal and Social Security/Medicare taxes.

Reduction Of Compensation
The amount by which the Company will reduce your compensation to make the Benefit Contributions will be stated in the Benefits Guide. The Company will set the Benefit Contributions and communicate them to you during the Open Enrollment Period for the upcoming Plan Year.

Treatment Of Benefit Contributions While On Leave
If you take an unpaid leave of absence, or a leave that is paid by someone other than DENSO (such as the STD or LTD insurer) you will not be able to participate in the Pre-Tax Payment Program. Please see the section titled "Participation During A Leave Of Absence" for more information about benefit contributions during your unpaid leave.

On the other hand, if you are on a paid leave that is paid by DENSO (whether or not FMLA-qualified), you will continue to participate in the Pre-Tax Payment Program and DENSO will continue to reduce your compensation to pay for the Benefit Programs you elected so long as you continue to be eligible to participate in the Benefit Programs.

DAY CARE FSA PROGRAM

The Day Care FSA Program is designed to help you pay your Eligible Dependent Care Expenses with pre-tax dollars. This lowers your income that is subject to federal, state, most municipal, and Social Security taxes. In effect, the money saved on taxes helps pay part of the Eligible Dependent Care Expenses normally paid with after-tax dollars.

Dependent Care Account
If you enroll in the Day Care FSA Program for a Plan Year, the Plan Administrator will establish a Dependent Care Spending Account ("**Dependent Care Account**") for the Plan Year. Your Dependent Care Account will be credited each pay period with the Benefit Contribution amount you authorized, The Dependent Care Account is for bookkeeping purposes only. The amounts credited to your Dependent Care Account are not assets that belong to you.

Annual Contribution Amount
The maximum amount you may contribute to your Dependent Care Account each Plan Year is the least of:

- your earned income from employment,
- your Spouse's earned income from employment, or
- $5,000 annually ($2,500 if married filing separately).

If your Spouse has not earned any income from employment, but is a Full-Time Student or disabled and unable to care for himself or herself, your Spouse will be assumed to have earned $250 a month if you claim reimbursement for the care of one Qualifying Individual, or $500 a month if you claim reimbursement for the care of two or more Qualifying Individuals. A "**Full-Time Student**" means an individual who, during each of at least five calendar months during the taxable year, is a full-time student at an educational organization.

If the amount of your or your Spouse's earned income changes during the Plan Year, so that your authorized contribution amount exceeds the maximum amount as stated above, you should immediately notify the Plan Administrator so that your authorized contribution amount can be reduced.

The Plan Administrator may also reduce your contribution to the extent necessary to comply with the Code's nondiscrimination requirements.

Amount That Can Be Reimbursed To Participants
Unlike the Health Care FSA Program, the Day Care FSA Program reimburses you for a Claim only to the extent of the balance in your Dependent Care Account. If the balance in your Dependent Care Account is insufficient to pay a Claim in full, the remainder of the Claim will be carried over and paid when the balance in your Dependent Care Account is sufficient. No reimbursement is available before the Eligible Dependent Care Expenses is Incurred. If you terminate employment or otherwise cease to be a Plan Participant before the end of the Plan Year, you will be able to continue to pay for Eligible Dependent Care Expenses, to the extent of any amounts remaining in your Dependent Care Account, that are Incurred from your date of termination or cessation of participation until the last day of the Plan Year. You cannot, however, carry over unpaid amounts to a subsequent Plan Year.

Eligible Dependent Care Expenses
The amount credited to your Dependent Care Account may only be used to pay for the Eligible Dependent Care Expenses of a Qualifying Individual. A "**Qualifying Individual**" is defined as:

- your child under the age of 13 for whom you are allowed a personal exemption deduction for federal income tax purposes; or

- your mentally or physically disabled Spouse or tax dependent (regardless of age) who is physically or mentally incapable to care for himself or herself and resides with you for at least one-half of your tax year and regularly spends at least eight hours per day in your home.

If you are a parent who is divorced, legally separated, separated under a written separation agreement, or who lived apart from your Spouse at all times during the last six months of the calendar year, your child will be considered a Qualifying Individual if:

- the child is under the age of 13 or is physically or mentally incapable of caring for himself;

- the child is in the custody of one or both parents for more than one-half of the calendar year; and

- you have custody of the child for more of the calendar year than your Spouse or former Spouse, as the case may be.

"**Eligible Dependent Care Expenses**" are expenses Incurred for household services or care of a Qualifying Individual necessary to enable you to be gainfully employed. Eligible Dependent Care Expenses also include Social Security and unemployment taxes paid by you on behalf of the person who cares for your Qualifying Individual.

You can receive reimbursement for the cost of services provided inside or outside your home as long as those services are not provided by your spouse, a person you or your spouse claims as a dependent for income tax purposes, or by one of your children under age 19. Expenses are eligible for reimbursement if you pay them to a dependent care center, a child care home or center, or a housekeeper whose services include providing care for the eligible dependent. Qualifying expenses include:

- Care in a qualified day care center. The qualified day care center must serve more than six children and it must comply with federal, state, and local regulations and receive payment or a grant for providing such care;

- Care for children in a private home. You must submit the private home provider's name, address and social security or federal ID number (EIN);

- Elder care for a Qualifying Individual in an adult day care center;

- Amounts paid to a baby sitter or nurse to care for a Qualifying Individual;

- The amount you pay for a Qualifying Individual child to attend a nursery school, even though the school provides lunch and educational services;

- The cost of care at a sick child center, but only to the extent that the care is not considered medical care reimbursable under any other program;

- Amounts paid to a housekeeper or cook for household services provided to a Qualifying Individual;

- Expenses for day camps to which you send a Qualifying Individual child during school vacations to enable you (and your spouse) to work;

- An expense incurred during a short-term, temporary (i.e., not exceeding two consecutive weeks) absence from work if your agreement with your caregiver requires payment during the absence; and

- Any other dependent care expenses considered "employment-related expenses" under Section 21(b) of the Internal Revenue Code. Contact your local HR/Benefits representative if you have questions concerning the eligibility of an expense.

Only expenses Incurred during the Plan Year for which you elected to be covered under the Day Care FSA Program may be claimed. Any amounts remaining in your Dependent Care Account at the end of the Plan Year will be forfeited. Amounts in your Dependent Care Account can only be used to pay for Eligible Dependent Care Expenses and not for Eligible Health Care Expenses.

Ineligible Dependent Care Expenses
There are certain kinds of dependent care expenses that do not qualify for dependent care reimbursement. These "**Ineligible Dependent Care Expenses"** include:

- expenses paid on behalf of an individual who is not a Qualifying Individual;

- expenses paid to your Spouse, a parent of a Qualifying Individual child, your or your Spouse's tax dependent, or your Child under age 19, to care for a Qualifying Individual;

- expenses for which you have received or will receive federal dependent care tax credits;

- expenses in excess of your annual elected amount or the maximum amount under the Day Care FSA Program;

- expenses paid to an ineligible provider (for example, expenses paid to send a dependent to an overnight camp or to a dependent care center that does not comply with all applicable state and local laws);

- babysitting expenses you Incur for a reason other than allowing you (and your spouse) to work (for example, for a social purpose);

- nursing home expenses for a Qualifying Individual confined to a nursing home;

- expenses for household services that are not related to the care of a Qualifying Individual;

- expenses Incurred during a period of time you were not covered by the Day Care FSA Program;

- expenses Incurred for food, clothing, or education, unless incidental to and inseparable from the care provided (for example, nursery school expenses are considered Eligible Dependent Care Expenses even if lunch and some educational services are provided);

- educational expenses for a child in kindergarten or a higher grade level;

- generally, expenses for transportation between your home and the place where the dependent care is provided;

- expenses for which you have not provided satisfactory proof of payment, i.e., you have not provided complete third-party substantiation as to the nature of the expense and the amount of your payment;

- expenses for which the name, address, and Social Security number or EIN of the dependent care provider has not been reported to the Claims Administrator;

- expenses submitted more than 90 days following the end of a Plan Year;

- expenses that are reimbursed or payable under any other similar plan or program; and

- expenses Incurred under any other FSA Program under this Plan.

Any reimbursement paid for an Ineligible Dependent Care Expense will be subject to applicable income taxes.

Example Of How The Day Care FSA Program Saves Taxes

You are married and you and your Spouse each earn $30,000 per year and you are in the 25% tax bracket. You estimate that your yearly Eligible Dependent Care Expenses will be $3,000. So, you choose to contribute $3,000 to your Dependent Care FSA. Your tax savings will be:

	Using Dependent Care FSA Program	**Not Using Dependent Care FSA Program**
Your Gross Pay (You and Your Spouse)	$60,000	$60,000
Your Pre Tax Dependent Care Expenses	3,000	N/A
Your Taxable Income	57,000	60,000
Your Income Taxes (25%)	14,250	15,000
Your Post Tax Dependent Care Expenses	0	3,000
Your Net Take Home Pay	$42,750	$42,000
Your Tax Savings	**$750**	N/A

Federal Dependent Care Tax Credit

You are not eligible to receive both the federal dependent care tax credit and reimbursement under the Day Care FSA Program for the same expense. Before enrolling in the Day Care FSA Program, you should determine that reimbursement under the Day Care FSA Program is more advantageous to you than the maximum federal dependent care tax credit ($3,000 for one child, $6,000 for two or more children).

The federal dependent care tax credit is reduced by the amount that the Day Care FSA Program reimburses you for child care expenses. For example, if you have two Qualifying Individuals for whose care you incur $7,000 in dependent care expenses, and you pay $5,000 on a tax-free basis through the Program, you cannot take a tax credit with respect to the entire remaining $2,000; you can only take a tax credit of $1,000. If you paid only $4,000 on a tax-free basis through the Day Care FSA Program, you could take the tax credit with respect to $2,000.

Provider Information
When you submit your first Claim of each year, you must provide the Claims Administrator with information about the dependent care provider including the provider's name, address and Social Security number or employer identification number. If this information changes at any time, you are required to provide the new information with your next Claim. This information must also be provided to the IRS on your income tax return. You may obtain this information from your dependent care provider on IRS Form W-10 "Dependent Care Provider's Identification and Certification."

Expenses Eligible Under More Than One Dependent Care Spending Account Program
If a dependent care benefit is payable under two or more dependent care spending account programs, you may submit a Claim for the expense to either program, but this Day Care FSA Program will not pay an expense paid by another program. At the Claims Administrator's request, you are obligated to supply additional information sufficient for the Claims Administrator to determine the existence of any duplication of Claims payments.

Forfeiture Of Amounts Remaining At The End Of The Plan Year
Because of Code requirements, if you do not use the total amount in your Dependent Care Account for reimbursement of Eligible Dependent Care Expenses Incurred during a Plan Year, the amount remaining at the end of the Plan Year will be forfeited and cannot be returned to you. An expense is "**Incurred**" on the date the service that gives rise to the expense takes place. Forfeited amounts will be used to pay the administration expenses of the Day Care FSA Program.

Termination Of The Day Care FSA Program
In the event the Day Care FSA Program is terminated by the Sponsoring Company, or your Company terminates its participation in the Day Care FSA Program, any amounts in your Dependent Care Account will remain available for reimbursement of expenses Incurred during the Plan Year while the Program was in effect until 90 calendar days after the date of termination of the Program.

Participation During A Leave Of Absence
If you take a leave of absence, based on the particular facts and circumstances of your leave, you may not be entitled to receive reimbursement for Claims Incurred during the period of your leave. You should contact your local HR/Benefits representative before taking a leave of absence to determine whether you will be able to reimburse dependent care expenses you incur during your leave.

HEALTH CARE FSA PROGRAM

The Health Care FSA Program is designed to help you pay for Eligible Health Care Expenses with pre-tax dollars. This lowers your income that is subject to federal, state, most municipal, and Social Security taxes.

If you elect to enroll in the OpenRoad option and the Health Care FSA Program, you will not be eligible to participate in the Health Savings Account Contribution Program.

Health Care Account

If you enroll in the Health Care FSA Program for a Plan Year, the Plan Administrator will establish a health care spending account ("**Health Care Account**") for you for that Plan Year. Your Health Care Account will be credited each pay period with the Benefit Contribution amount you authorized. Your Health Care Account is for bookkeeping purposes only. The amounts credited to your Health Care Account are not assets that belong to you.

Annual Contribution Amount

You may contribute to your Health Care Account up to the maximum contribution amount each Plan Year. The maximum contribution amount, at the Company's sole discretion, may be adjusted annually for inflation as permitted by law. The maximum contribution limit will be described in your election materials. The Plan Administrator, however, may reduce your contribution amount to the extent necessary to comply with certain nondiscrimination requirements under the Code.

You are permitted to carry over into the following Plan Year up to $500 of unspent funds ("**Carry-Over Amount**"). The Carry-Over Amount will be available to you the following Plan Year as long as you remain an active associate and eligible to participate in the Health Care FSA Program, even if you decide not to contribute to the Health Care FSA Program for that Plan Year. But if you terminate your employment or lose your eligibility to participate in the Health Care FSA Program, then your participation in the Health Care FSA Program will end and you will forfeit the Carry-Over Amount unless you elect to continue coverage under COBRA, if available.

Because Carry-Over Amounts in your Health Care Account effectively extend your coverage under the Health Care FSA Program through the next Plan Year, a positive balance in your Health Care Account at the end of one Plan Year will make you, your Spouse, and other Covered Dependents ineligible to make HSA contributions or accept Company HSA contributions for the next Plan Year. Therefore, if you choose to participate for the next plan year in the OpenRoad option under the Medical Program and you also want to participate in the HSA Program, you must decline contributions to the Health Care FSA Program and waive any Carry-Over Amount prior to the start of the next Plan Year.

Amount That Can Be Reimbursed To Participants

Immediately upon your participation in the Health Care FSA Program for a Plan Year, the full annualized value of the amount you elected to contribute will be available to reimburse you for Eligible Health Care Expenses Incurred during that Plan Year. For example, if you have elected to contribute $1,200 to your Health Care Account for the Plan Year, you may be reimbursed in full for a $1,200 Claim Incurred on your first day of participation for that Plan Year.

Unlike the Day Care FSA Program, the Health Care FSA Program reimburses you for a Claim even if the balance in your Health Care FSA is insufficient to pay the Claim, as long as the Claim does not exceed the total amount of your elected Benefit Contributions under the Health Care FSA Program for the Plan Year, including any Carry-Over Amount, less any previously paid Claims. However, because Carry-Over Amounts are not determined until the end of the Claims run-out period for the prior Plan Year, Claims submitted in the first 90 days of the Plan Year will be reimbursed only to the extent they do not exceed your elected Benefit Contributions for the Plan Year excluding Carry-Over Amounts, less any previously paid Claims. If you submit a Claim in the first 90 days of the Plan Year and it exceeds this amount, the Claim will be held and reimbursed once the Carry-Over Amount has been determined.

For example, if you have elected to contribute $1,000 under the Health Care FSA Program, you could be reimbursed in full for the $1,000 Claim incurred on your first day of participation in the new Plan Year. If, however, your Claim was for $1,100, you would receive partial reimbursement in the amount of $1,000 and a second reimbursement of the additional $100 once the Claims run-out period for the prior Plan Year has expired and it is determined that you have a Carry-Over Amount sufficient to pay the additional $100.

Once your Carry-Over Amount is determined, your Claims will be reimbursed first from your Carry-Over Amount and then from your Benefit Contributions for the current Plan Year.

Eligible Health Care Expenses

The amount credited to your Health Care Account can only be used to pay for your or a Qualified Dependent's Eligible Health Care Expenses Incurred while you were covered under the Health Care FSA Program. If your participation in the Health Care FSA Program terminates after the start of the Plan Year, you will be permitted to spend down any Carry-Over Amount.

A "**Qualified Dependent**" is:

- your Spouse, or
- any individual that you can claim as a dependent on your federal income tax return under Code Section 152;
- your adult Child through the end of the month in which he or she turns age 26.

"**Eligible Health Care Expenses**" for the Health Care Account are expenses that qualify as medical care under Sections 213(d)(1)(A) and (B) of the Code and are for the benefit of a Qualified Dependent. These generally include unreimbursed expenses Incurred for diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body and for transportation essential to obtaining related services. Eligible Health Care Expenses do not include payment for long-term care services or insurance.

For example, Eligible Health Care Expenses under the Health Care FSA include amounts paid for:

- hospital expenses;
- medical, dental, or vision expenses;

- over-the-counter drugs, medications or biologicals purchased for medical care, such as antacids, allergy medicine, pain relievers, and cold medications that are obtained with a doctor's prescription;

- prescription drugs; and

- insurance deductibles and copayments that are not reimbursed by another insurance plan or reimbursement account.

Only expenses Incurred during the Plan Year for which you elected to be covered under the Health Care FSA Program may be claimed. Any amounts remaining in your Health Care Account at the end of the Plan Year will be forfeited. Amounts in your Health Care Account can only be used to pay for Eligible Health Care Expenses, and not for Eligible Dependent Care Expenses.

Ineligible Health Care Expenses
There are certain kinds of "**Ineligible Health Care Expenses**" that do not qualify for reimbursement. These include:

- expenses for over-the counter drugs, medications or biologicals purchased for medical care that are obtained without a doctor's prescription;

- expenses paid on behalf of an individual who is not a Qualified Dependent;

- expenses that are payable under any other insurance plan or group health plan (including one sponsored by the Company) or that were paid under another employer's health care spending account program (at the Claims Administrator's request, you are obligated to supply additional information sufficient for the Claims Administrator to determine the existence of any duplication of Claims payments);

- expenses for which you have received, or will receive, an itemized deduction on your federal tax return;

- expenses for premiums for insurance not provided by your employer (for example, premiums paid for your Spouse's insurance);

- expenses in excess of the annualized elected amount, plus any Carry-Over Amount;

- expenses Incurred during a time you were not covered by the Health Care FSA Program, except you will be permitted to spend down the Carry-Over Amount;

- over-the-counter medications or drugs that are merely beneficial to general health, such as vitamins and dietary supplements;

- expenses for which you have not provided satisfactory proof of payment;

- expenses submitted later than the March 31st following the end of Plan Year or later than 60 days following separation of employment, whichever is sooner; and

- expenses Incurred under the Day Care FSA Program.

Any reimbursement paid for an Ineligible Expense under the Health Care FSA Program will be subject to income taxes as applicable.

Example of How The Health Care FSA Program Saves On Taxes

You earn $30,000 per year and you are in the 25% tax bracket. You estimate that your yearly Eligible Health Care Expenses will be $1,500. So, you choose to contribute $1,500 to your Health Care FSA. Your tax savings will be:

	Using Health Care FSA Program	**Not Using Health Care FSA Program**
Your Gross Pay	$30,000	$30,000
Your Pre Tax Health Care Expenses	1,500	N/A
Your Taxable Income	28,500	30,000
Your Income Taxes (25%)	7,125	7,500
Your Post-tax Health Care Expenses	0	1,500
Your Net Take Home Pay	$21,375	$21,000
Your Tax Savings	**$375**	N/A

Federal Itemized Deduction

You are not entitled to receive both a federal itemized deduction for medical expenses and a reimbursement under the Health Care FSA Program for the same expense. Before enrolling in the Health Care FSA Program, you should determine whether reimbursement of Eligible Health Care Expenses under the Health Care FSA Program is more advantageous than the federal itemized deduction. For those employees whose Eligible Health Care Expenses never exceed 10% of their adjusted gross income, reimbursement under the Health Care FSA Program will likely be more advantageous.

Expenses Eligible Under More Than One Health Care Spending Account Program

If a health care benefit is payable under two or more health care spending account programs, you may submit a Claim for the expense to either program, but this Health Care FSA Program will not pay an expense paid by another program. At the Claims Administrator's request, you are obligated to supply additional information sufficient for the Claims Administrator to determine the existence of any duplication of Claims payments.

Forfeiture Of Amounts Remaining At The End Of The Plan Year or Termination of Participation

Because of Code requirements, if you do not use the total amount in your Health Care Account for reimbursement of Eligible Health Care Expenses Incurred during a Plan Year, the amount remaining, less any Carry-Over Amount, at the end of the Plan Year will be forfeited and cannot be returned to you. Also, if your employment terminates or your participation in the Health Care FSA Program ends because you no longer satisfy the eligibility requirements, the amount in your Health Care FSA, including any Carry-Over Amount, will be forfeited, unless you elect to continue

coverage in the Health Care FSA Program under COBRA or USERRA when applicable. You will have until the March 31st following the end of the Plan Year or 60 days following your termination of participation, whichever is sooner, to submit Eligible Health Care Expenses Incurred during the Plan Year or while you were a participant in the Health Care FSA Program, whichever applies. The Plan Administrator will use forfeited amounts to pay the administration expenses of the Health Care FSA Program, or otherwise apply the forfeitures as permitted under applicable law.

Participation During An Unpaid Leave Of Absence
If you take an unpaid leave of absence (or a paid leave that is paid by someone other than DENSO), you have the following options under the Health Care FSA Program:

- Revoke your coverage under all Benefit Programs, including the Health Care FSA Program and discontinue making contributions to your Health Care Account. You are not entitled to receive reimbursements for Claims Incurred during the period your Health Care FSA Program coverage is terminated. Upon your return from your leave during the same Plan Year, you resume participation in the Health Care FSA Program and your Health Care Account is reinstated. When you begin again to participate in the Health Care FSA Program, you may either:

  - resume coverage at the level in effect before your leave started and increase your before-tax salary reductions for the remaining portion of the Plan Year to make up the unpaid before-tax contributions; or
  - resume coverage under the Health Care FSA Program at a reduced level (the level of coverage is pro-rated for the period during which no contributions were made) and keep your Benefit Contributions at the same level in effect before your leave.

  In both cases, the coverage level is reduced by prior reimbursements.

- Continue your coverage under the Health Care FSA Program during your leave, but discontinue contributions. The full annualized value of the amount you have elected to contribute to the Health Care FSA Program, less any prior reimbursements, will be available to reimburse you for Eligible Health Care Expenses Incurred during your leave. Upon your return from leave, DENSO will deduct your missed contributions from your pay on a pre-tax basis.

HEALTH SAVINGS ACCOUNT CONTRIBUTIONS PROGRAM

The HSA Program allows you to reduce your taxable compensation by making pre-tax contributions to a Health Savings Account ("**HSA**") established in your name. Although you can use the funds in your HSA for any purpose, these funds will be tax free when you use them to reimburse medical expenses consistent with federal tax code requirements. For more information on qualifying medical expenses, you should obtain and read the most current version of IRS Publication 969.

You are the owner of your HSA, and the Company has no authority or control over the funds deposited in your HSA. Even though this plan allows you to make pre-tax contributions to your HSA, your HSA is not an ERISA benefit plan sponsored or maintained by the Company. It will be up to you to decide when and how to use the funds in your HSA.

Eligibility
In order to contribute to an HSA through the HSA Program, you: (1) must be eligible for and participating in the Medical Program's OpenRoad option; (2) may not be claimed as a dependent on anyone else's tax return; and (3) may not be covered by any other medical plan that provides coverage below the deductible threshold established under the federal tax code (these thresholds will be communicated to you annually). Other coverage that will disqualify you from contributing to an HSA includes Medicare Parts A, B, or D; a Medicare Advantage plan; coverage under a Spouse's medical plan that is not an HDHP; coverage under a health FSA, unless it is a limited-purpose or post-deductible FSA; Veterans Administration medical benefits received during the preceding three months, unless you have been determined to have a service-related disability; coverage under the TRICARE program; Indian Health Service medical benefits received during the preceding three months; and any other coverage that covers all or even a portion of medical expenses that you incur before you have satisfied the deductible threshold.

Employees participating in the Health Care FSA Program are not eligible to participate in this HSA Program.

Benefits
If you are eligible to participate in the HSA Program, you may reduce your taxable income by having the Company submit your elected contributions on a pre-tax basis to an HSA that you establish with the HSA trustee/custodian selected by the Company.

The Company, at its sole discretion, may elect to make additional pre-tax contributions to your Health Savings Account. If a contribution is made by the Company for any Plan Year, the amount of contribution to your Health Savings Account will be periodically communicated to you in writing, along with the timing of any such contributions and requirement to receive contributions. If you do not timely establish an HSA Account or submit the HSA contribution form by the deadline described below in "Establishing an HSA Account", you will forfeit any Company HSA contributions that you otherwise would have received.

Establishing an HSA Account
If you choose to participate in the HSA Program, you must establish an HSA with Optum Bank. Information on establishing your HSA is available from the Plan Administrator. You should establish your HSA as soon as possible, as federal tax rules prohibit you from using HSA funds to reimburse medical expenses incurred prior to the date you establish the account. If you have not fully established your HSA by the earlier of the end of the fourth calendar month after the date you enrolled in the HSA Contributions Program or the end of the Plan Year, you will forfeit any Company HSA contributions that you otherwise would have received during that time. Additionally, if you are an existing participant in the Plan's OpenRoad Medical Program option, you must submit the HSA contribution form (or another form developed by the Plan Administrator) by April 30 each year, or else forfeit any Company HSA contributions that you would have received during that time.

You are responsible for opening your HSA with the designated HSA custodian, which includes executing a custodial agreement, and you will be the owner of any contributions deposited into the HSA. The HSA is subject to the terms and conditions of the HSA custodian agreement that will be provided to you. You are solely responsible for any fees assessed by the HSA custodian.

You may transfer funds from the HSA to another HSA with the custodian of your choice at any time. The Company, however, will only contribute funds to an HSA with the custodian of its choosing. If you transfer funds to another HSA, you must keep your HSA with the Company's designated HSA custodian open and active to ensure that the Company can deposit your contributions to the HSA. If you close the account with the designated HSA custodian, you will forfeit any Company contributions attempted while your account is closed and any HSA contributions deducted from your pay while the account is closed will be returned to you as taxable income.

Changing Contributions

Each pay period, you can elect to increase, decrease, or entirely stop contributing to your HSA. These changes will not affect your prior contributions, but only contributions you make going forward. Your change will go into effect with the next payroll period that begins after you have successfully submitted your election change, or as soon thereafter as administratively feasible.

Maximum Contributions

General Limitations on Contributions

The maximum amount that you may contribute to your HSA may not exceed the limits established under the federal tax code. If you are age 55 or older, you may also elect to make an additional "catch-up" contribution. These maximum contribution limits are adjusted periodically for inflation and will be communicated to you annually.

If you are married and both you and your spouse have an HSA, the IRS has a special rule limiting your joint contributions for the year to the family deductible limit. Thus, if you have family coverage, the combined contributions to your and your spouse's HSAs may not exceed the maximum contribution limit for family coverage established under the federal tax code for that year. If both you and your spouse are above age 55 and each of you establish an HSA, then you may both also make an additional "catch-up" contribution to each account. If only you have an HSA, then only you can make a "catch-up" contribution. For more information about the rules that apply to married people, you should obtain and read the most current version of IRS Special Publication 969.

The maximum contribution amount is also pro-rated for the number of months of the year that you are eligible to contribute to an HSA. Thus, if you lose eligibility to contribute to an HSA mid-way through the year, your maximum contribution amount will be reduced. You are responsible for determining whether you remain eligible to contribute to an HSA and for adjusting your HSA contributions accordingly.

When planning your contributions for the year, you must reduce your maximum contribution limit by any contribution that the Company makes on your behalf. If you have family coverage and your spouse also contributes to an HSA, then you must also reduce your maximum HSA contribution limit for family coverage by the amount that your spouse contributes.

If the total deposits into your HSA for the year exceed your maximum contribution limit, the excess amounts will be deemed an excess contribution for federal tax purposes. You will be taxed on this excess contribution. Additionally, if you do not promptly withdraw this excess contribution (and any income earned on the excess contribution), you will pay a 6% excise tax each year that the excess contribution (and its earned income) remains in your HSA.

Limits for Those Not Eligible to Contribute to an HSA For the Full Year

The amount that you may contribute may also have to be pro-rated for the number of months of the year that you are eligible to contribute to an HSA (see the "Eligibility" section above). For example, if you terminate employment with the Company on June 15 and are no longer covered under a high deductible health plan for the rest of the calendar year, you will only be eligible to contribute to an HSA for the first six months of the year and your maximum contribution amount will be reduced to half of the annual limit. This pro-rata contribution rule also applies to catch-up contributions during the year you turn age 55.

If you join the Plan after the start of the year and have not been previously covered under a high deductible health plan, the amount you may contribute without restriction is also prorated for the number of months you are covered by the OpenRoad option (and are otherwise eligible to contribute to an HSA). However, the IRS has a special rule that allows you to fund your HSA up to the annual contribution limit for a calendar year as long as you are covered under a high-deductible health plan by December 1 of the year. This special rule is called the "Last-Month Rule." To take advantage of this Last-Month Rule, you are required to remain covered under a high deductible health plan (and not otherwise be disqualified from contributing to an HSA) until the end of the following calendar year. If you fail to remain HSA eligible throughout the following calendar year, you would face adverse tax consequences: you would have to pay income taxes plus an additional 10% penalty tax on the contributions above your prorated contribution limit (except if you lose your HSA eligibility based on disability or death). You do not, however, have to withdraw the contribution in excess of the pro-rated amount (and you would be subject to an additional 20% penalty if you tried to withdraw the contribution for any purpose other than paying for qualifying medical expenses).

The Last-Month Rule also applies to catch-up contributions that you make during the year you turn age 55. As long as you are age 55 by December 1 of the calendar year, you can contribute the entire catch-up amount for the year. But if you do not remain eligible to contribute to an HSA during the entire following calendar year, you would have to pay income taxes plus an additional 10% penalty on the amount of the catch-up amount that exceeds the pro-rated amount you were otherwise allowed to contribute.

You are responsible for determining whether you are eligible to contribute to an HSA each month and for adjusting your HSA contributions accordingly. For more information about the Last-Month Rule, you should obtain and read the most current version of IRS Publication 969.

Recording Contributions

Because you are the owner of your HSA, you are responsible for keeping track of how much has been deposited into your account. The Company will keep track of HSA contributions made through this Plan, but will not keep track of contributions made outside of the Plan or of amounts that your Spouse may contribute to an HSA. Nor will the Company keep track of whether you maintain eligibility to contribute to an HSA throughout the year. Also, the Company will not create any separate fund or otherwise segregate assets relating to the Health Savings Account Contribution Program.

Trust/Custodial Agreement
Your HSA is a personal account that you own, not an employee benefit program sponsored by The Company. To establish the HSA, you must execute a custodial agreement with an HSA custodian. Additionally, your HSA is subject to terms and conditions, which the HSA custodian will provide to you. You are solely responsible for any fees assessed by the HSA custodian.

HSA Distributions
This Plan does not govern distributions from your HSA. Distributions and all other matters relating to maintenance of your HSA are subject to the trust/custodial agreement between you and the HSA custodian. You are solely responsible for complying with federal tax rules regarding distributions from your HSA and any tax consequences associated with those distributions. For more information about HSA distribution rules, you should obtain and read the most current version of IRS Publication 969.

Termination
When your participation in this Plan ends, pre-tax contributions to your HSA will also end. You will continue to be the owner of your HSA. If you terminate mid-year and are no longer eligible for HSA contributions, you may be taxed on any contribution that the Company has made to your HSA on a prorated basis (and possibly on some or all of the additional contributions that you have made). Also, the IRS may treat a portion of the Company contribution and your additional contributions as an excess contribution. You will need to promptly withdraw the excess contribution (and any interest earned on that amount) from your HSA or pay a 6% excise tax each year that the excess contribution (and interest on the excess contribution) remains in your HSA.

BUSINESS TRAVEL ACCIDENT INSURANCE PROGRAM

For description of the Business Travel Accident Insurance Program benefits, please refer to the Booklet provided by the Claims Administrator listed in the Benefit Program & On-Site Medical Health Centers Information Chart.

ON-SITE MEDICAL PROGRAM

For description of On-Site Medical Program benefits, please refer to the Booklet provided by the Claims Administrator listed in the Benefit Program & On-Site Medical Health Centers Information Chart.

HEALTHY HORIZONS PROGRAM

For description of the Healthy Horizons Program benefits, please refer to the Booklet provided by the Claims Administrator listed in the Benefit Program & On-Site Medical Health Centers Information Chart.

IMPORTANT INFORMATION ABOUT THE PLAN

FILING AND PROCESSING CLAIMS

For the claims procedures under each Benefit Program, **first consult the applicable Booklets provided by the insurer or Claims Administrator. The procedures described in this section are intended to comply with ERISA's claims requirements and, to the extent necessary to comply with those requirements, to supplement the information provided in the applicable Booklets.** If there is an inconsistency in the claims procedures described in this section and those described in the Booklets, the Booklets will control. If the Booklets for a Benefit Program do not contain claims procedures, the procedures described in this section for that Benefit Program will apply.

General Rules

A "**Claim**" is any request for a Plan benefit made in accordance with the Plan's procedures, or a claim or allegation by a claimant that the Plan Administrator, a Plan fiduciary, or the Company has violated ERISA or the Code.

A Claim may be filed, and an appeal of a denied Claim may be sought, by any Participant or Covered Dependent. A claimant may appoint an authorized representative to file a Claim on his or her behalf and to communicate with the Plan with respect to any Claim or appeal. To appoint an authorized representative, request the appropriate forms from the Plan Administrator. The Plan Administrator will consider the claimant's most recent appointment of an authorized representative to supersede any appointments made previously. The Claims Administrator will communicate directly with the authorized representative and may send a copy of those communications to the claimant. If no representative is appointed, the Claims Administrator will communicate with the claimant directly. For the Medical, Dental, and Vision Programs, health care providers with knowledge of the claimant's condition will also be treated as authorized representatives. The Plan Administrator will also recognize as an authorized representative a person legally appointed to represent a claimant (e.g., a court-appointed representative in the case of a claimant's incapacitation), provided that Claims under the applicable Benefit Program fall within the scope of that representation.

The entity or individual that is responsible for determining a Claim under a particular Benefit Program is referred to as the "**Claims Administrator**." Refer to the Benefit Program & On-Site Medical Health Centers Information Chart for the Claims Administrator for each Benefit Program. The Claims Administrator who reviews a denied Claim may be different than the Claims Administrator who reviews the initial Claim.

No Claim for a benefit will be paid or reimbursed prior to the date on which the expense was incurred. **An expense is considered incurred on the date the services are performed and not when you are billed or make a payment**; **except that for purposes of the Health Care FSA Program, if your dental provider requires advanced payment for orthodontia procedures, those orthodontia procedures will be considered incurred on the date you make the advanced payment.**

Claims Under Group Health Plans: Medical, Dental, Vision, EAP, Health Care FSA, On-Site Medical, and Healthy Horizons Programs

This section describes the procedures for filing and processing most Claims under the Plan's group health plans which include the Medical, Dental, Vision, EAP, Health Care FSA, On-Site Medical, and Healthy Horizons Programs. If your Claim is for a benefit conditioned upon the Claims Administrator's determination of a disability, see "Claims Under the Short-Term Disability and Long-Term Disability Programs and Claims Under Other Benefit Programs for Benefits Conditioned Upon the Claims Administrator's Determination of Disability" for additional requirements that may apply.

The rules pertaining to the processing of Claims under the Plan's group health plans vary based on whether a Claim is a Pre-Service Claim, a Post-Service Claim, an Urgent Care Claim, or a Concurrent Care Claim.

A **"Pre-Service Claim"** is a Claim for health care that is conditioned, in whole or in part, on your obtaining approval before receiving the care (e.g., pre-authorization or pre-certification).

An "**Urgent Care Claim**" is a Pre-Service Claim where applying the standard time frames for a Pre-Service Claim:

- could seriously jeopardize your life or health or your ability to regain maximum function; or

- would, in the opinion of a physician with knowledge of your medical condition, cause you severe pain that cannot be managed adequately without the care or treatment that is the subject of the Claim.

If your physician does not identify your Claim as an Urgent Care Claim, the Plan will determine whether the Claim is an Urgent Care Claim using the judgment of a prudent layperson with average knowledge of health and medicine.

A **"Concurrent Care Claim"** is a Claim related to: (i) the reduction or termination of a previously approved course of treatment; or (ii) the extension of a previously approved course of treatment.

A "**Post-Service Claim**" is a Claim for health care that is not conditioned, in whole or in part, on your obtaining approval before receiving the care (e.g., pre-authorization or pre-certification).

Filing a Claim

Pre-Service Claims

If you are required to obtain approval before receiving care, your health care provider will typically submit your Pre-Service Claim for you. Pre-Service Claims may be submitted by mail, telephone, or electronic media to the Claims Administrator. The Claims Administrator may require substantiation by a third party that is independent of you, your Spouse or your dependents (e.g., your health care provider) including, but not limited to, a statement of: (1) the anticipated service, treatment, or procedure; (2) the anticipated date of the service, treatment, or procedure; and (3) an estimate of the cost of the service, treatment, or procedure.

If you or your health care provider are seeking pre-approval and you do not properly submit the Pre-Service Claim, the Claims Administrator will notify you within five days and explain what steps you must take to properly file your Claim. The Claims Administrator may provide the notification orally unless you request written notification.

Approval of your Pre-Service Claim serves only to meet the Plan's pre-approval requirement so that you will not be penalized. Pre-approval is not a guarantee that the Claim will be paid in full, as there may be other reasons to deny your Claim. Once the treatment is provided, the provider's bill will be processed as a Post-Service Claim.

Urgent Care Claims

If you need urgent health care that requires pre-approval, your health care provider will typically submit your Urgent Care Claim. Urgent Care Claims may be submitted to the Claims Administrator orally or in writing, and all necessary information may be provided by telephone, facsimile, or any other similarly expeditious method. The Claims Administrator may require substantiation by a third party that is independent of you, your Spouse or your dependents (e.g., your health care provider) including, but not limited to, a statement of: (1) the service, treatment, or procedure; (2) the date of the service, treatment, or procedure; and (3) the cost of the service, treatment, or procedure.

If you or your health care provider have not properly submitted an Urgent Care Claim under the Plan's Claims procedures, the Claims Administrator will notify you within 24 hours and explain what steps you must take to properly file your Claim. The Claims Administrator may provide the notification orally unless you request written notification.

Concurrent Care Claims

If you have been approved for a course of treatment under the Medical Program and you wish to extend the course of treatment beyond what was initially authorized, you may file a "**Concurrent Care Claim**" to request the extension. You must submit all information in support of your Concurrent Care Claim to the Claims Administrator at least 24 hours prior to the scheduled expiration of the course of treatment. The Claims Administrator may require substantiation by a third party that is independent of you, your Spouse or your dependents (e.g., your health care provider) including, but not limited to, a statement of: (1) the service, treatment, or procedure to be extended; (2) the duration of the extension of the service, treatment, or procedure; and (3) the cost of the extended service, treatment, or procedure.

Post-Service Claims

Once you have received care, your health care provider will typically submit your Post-Service Claim for you. If you have paid for services out of your own pocket, or the provider has sent a bill directly to you for payment, you should obtain a Claim form from the Plan Administrator or the Claims Administrator. Post-Service Claims may be submitted to the Claims Administrator in writing or by any reasonably available electronic media.

The Claims Administrator may require substantiation by a third party that is independent of you, your Spouse or your dependents (e.g., your health care provider) including, but not limited to, a statement of: (1) the service, treatment, procedure, or product; (2) the date on which you received or underwent the service, treatment, or procedure, or the date on which you purchased the product; and (3) the amount charged. The Claims Administrator may also require your Claim

to include a completed Claim form (including any documentation required by the Claim form) and, if you have already paid for the service, treatment, procedure or product, evidence of payment (e.g., a cancelled check, receipt, an invoice marked "paid," etc.). For Claims under the Health Care FSA Program, you will also be required to certify that you have not been reimbursed for, and will not seek reimbursement of, the expense under any other plan.

Deadline for Post-Service Claims Under Medical, Dental, Vision, EAP, On-Site Medical, Healthy Horizons Programs
You are encouraged to submit your Post-Service Claims under the Medical, Dental, Vision, EAP, On-Site Medical, and Healthy Horizons Programs as soon as possible after you incur the expense. Unless otherwise specified in the applicable Insurance Contracts or Booklets, Post-Service Claims under these Programs must be submitted within 12 months of the date the expense was incurred.

Deadline for Post-Service Claims Under Healthy Horizons Program
Typically, you will not be required to file Claims to receive benefits under the Healthy Horizons Program. However, you may be required to submit to the Plan Administrator documentation sufficient to demonstrate that you completed required tasks and/or achieved required outcomes. See the description of the Healthy Horizons Program and the applicable Booklets for more information.

If you think you have been improperly denied a benefit under the Healthy Horizons Program, you must submit your Claim within 90 days of the end of the Plan Year.

Deadline for Post-Service Claims Under Health Care FSA Program
To obtain reimbursement of Eligible Health Care Expenses incurred during a Plan Year, you must submit a Claim to the Claims Administrator within 90 days of the end of the Plan Year.

Filing Debit Card Claims Under the Health Care FSA Programs
Upon enrollment, the Company will issue to you a debit card to pay for Eligible Health Care Expenses under the Health Care FSA Program. You may use the card only at eligible network pharmacies and only for the purchase of prescription drugs. The debit card is only valid up to the value of your Health Care FSA. Each time you use the card, your Health Care FSA balance will be reduced by the amount of the transaction. If you do not pay for your Eligible Health Care Expenses with your debit card, you must file a paper or online Claim in order to receive reimbursement. The card will be automatically cancelled when your participation in the Health Care FSA Program ends.

When the card is issued, you will be required to certify that: (i) you will only use the debit card for reimbursable expenses that have not already been reimbursed; (ii) you will not seek reimbursement under any other health plan for an expense paid for with the card; and (iii) you will retain sufficient documentation for any expense paid for with the card (e.g., invoices and receipts). The card will carry a statement on the back that you reaffirm this certification each time you use the card.

Each time you make a purchase with the card, you must obtain a statement (e.g., an invoice or receipt) from the merchant or provider that includes the following information:

- Nature of the expense (e.g., the type of drug that was dispensed);

- Date the expense was incurred; and

- Amount of the expense.

You must retain the statement after the close of the Plan Year in which the expense is incurred to prove that you used the debit card for a reimbursable expense. You should keep these statements with your tax records.

Under certain circumstances, the Claims Administrator is required to substantiate debit card transactions and will request that you submit the statement, along with the following information:

- Name and address of the person, organization or entity to which the expense was paid;

- Name of the person for whom the expense was incurred, and the person's relationship to you; and

- Amount recovered or recoverable from any other source with respect to the expense.

You will be given at least 45 days from the date of the request to provide this information. If you fail to provide it, or it is determined that you have used the card for other expenses, your use of the card will be suspended and you will be issued a notice of initial claim denial including the deadline by which you must repay the amount of the expense. If you do not repay the expense, it will be automatically deducted from your paycheck. The Company may take other actions permitted by law to recover the expense. Your card will be reactivated once payment has been made.

The Claims Administrator will not require you to provide a written statement under these circumstances:

- Dollar amount of the transaction equals the dollar amount of the copayment, if any, for that expense; or

- Transaction is a recurrence of a previously approved expense as to amount, provider, and time period.

- Merchant or provider, at the time of the transaction, provides information to verify that the charge is for a reimbursable expense. If not automatically verified through use of an inventory information approval system, this information may be provided by telephone, mail, e-mail, the internet, or any other method acceptable to the Claims Administrator.

Notice of Initial Claim Determination

Timing of Notice of Initial Claim Determination

Pre-Service Claim

If your Claim is a Pre-Service Claim, the Claims Administrator will notify you of its determination (whether adverse or not) within a reasonable period of time considering the medical circumstances, but not later than 15 days after receipt of the Claim, or 30 days if the Claims Administrator determines an extension is necessary due to matters beyond the control of the Plan

and notifies you within the original 15-day period of the reason for the extension and date by which the determination is intended to be made. If the extension is necessary because you failed to submit a complete Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Urgent Care Claim
If your Claim is an Urgent Care Claim, the Claims Administrator will notify you of its determination (whether adverse or not) as soon as possible taking into account the medical circumstances, but no later than 72 hours after receipt of the Claim, unless your Claim is incomplete. If your Urgent Care Claim is incomplete, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the Claim, of the information necessary to complete the Claim. You will be given a reasonable period of time, but not less than 48 hours, to provide the necessary information; and the Claims Administrator will notify you of its determination within 48 hours of receipt of that information. If you fail to provide the information in a timely manner, the Claims Administrator will make its determination based on the information it has and will notify you of its determination within 48 hours of the deadline for providing the necessary information.

Concurrent Care Claim
The reduction or termination of a previously approved course of treatment is considered a denial of a Concurrent Care Claim. In this circumstance, the Claims Administrator will issue a Notice of Initial Claim Denial sufficiently in advance of the reduction or termination to allow you to exercise your right of appeal and obtain a determination before the benefit is reduced or terminated.

If your Concurrent Care Claim is for the extension of a previously approved course of treatment, the Claims Administrator will notify you of its determination (whether adverse or not) within 24 hours after receipt of the Claim.

Post-Service Claim
The Claims Administrator is not required to notify you of its determination for a Post-Service Claim unless the Claim is denied. If a Post-Service Claim is denied, the Claims Administrator will provide you with a Notice of Initial Claim Denial within a reasonable period of time, but not later than 30 days after receipt of the Claim, or 45 days if the Claims Administrator determines an extension is necessary due to matters beyond the control of the Plan and notifies you within the original 30-day period of the reason for the extension and date by which the determination is intended to be made. If the extension is necessary because you failed to submit a complete Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Form and Content of Notice of Initial Claim Denial
Any adverse benefit determination, including any denial, reduction, or termination, in whole or part, of the benefit for which you filed a Claim, or any rescission of coverage, is a Claim denial. This includes any determination based on the eligibility of the person on whose behalf the expense was incurred or whether the expense itself is eligible for reimbursement.

If your initial Claim is denied in whole or in part, or if your coverage is rescinded or terminated for cause, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail)

explanatory notice of its determination in a culturally and linguistically appropriate manner. The notice of initial claim denial will:

- provide information to help you identify the Claim including, upon request and when applicable, the diagnosis and treatment codes and the meanings of those codes;

- inform you of the specific reasons for the denial of your initial Claim and any denial code and its corresponding meaning;

- inform you of the pertinent Plan provisions on which the denial is based;

- describe any rule, standard, guideline, protocol, or similar document or criteria relied on in making the initial determination; or include a statement that the rule, standard, guideline, protocol, or similar document or criteria was relied on and that a copy of it may be obtained at no charge upon request;

- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, explain the scientific or clinical judgment for the denial, or include a statement that an explanation will be provided free of charge upon request;

- describe any additional materials necessary to perfect your Claim, and explain why this material is necessary;

- include an explanation of the Plan's internal and external appeal procedures, including information about how to initiate an appeal and the applicable time limits; and a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures;

- provide contact information for an office of health insurance consumer assistance or a health insurance ombudsman program, if such a service has been established in your state.

Special Rules for Urgent Care Claims

The notice of initial claim denial for an Urgent Care Claim may be provided orally, with a written or electronic notice to follow within three days. In addition to the information listed above, the notice of initial claim denial for an Urgent Care Claim will include an explanation of the expedited review process available for such claims.

Filing an Appeal

If you receive a notice of initial claim denial and you wish to challenge the denial, you must file an appeal with the Claims Administrator within 180 days of receipt of the notice of initial claim denial. Your appeal must be in writing and transmitted either by mail or a reasonably available electronic media. Your appeal must explain why you think your Claim should not have been denied and include any additional information, materials, or documentation supporting your Claim. You may also submit written comments, documents, records, and other information relating to your Claim. Upon request and free of charge, you will be provided with reasonable access to, and copies of, all documents, records and other information relevant to your Claim.

Review of Appeal
The persons reviewing your appeal will grant no deference to the original Claim denial or the first-level appeal decision, if applicable, but will assess the information you provide as if they were looking at the Claim for the first time. Also, the persons reviewing your appeal will not be the same persons who made the initial decision or reviewed the prior appeal (if any), nor will they be subordinates of those individuals. Upon request and free of charge, you will also be provided reasonable access to and copies of, all documents, records, and other information relevant to your Claim.

If the initial Claim denial or the first-level appeal of your Claim, if applicable, is based on medical judgment (e.g., it was based on an assessment that your treatment was experimental or was not medically necessary), the Claims Administrator must consult with an expert in the appropriate field when reviewing the Claim. The expert will not be someone who was consulted in the initial review of your Claim or a subordinate of anyone consulted in that review. The identity of any expert consulted, whether or not his or her opinion is relied on in determining your Claim, will be retained as information relevant to your Claim.

Expedited Review for Urgent Care Claims
You may request an expedited review for an Urgent Care Claim. Your request may be made orally or in writing and all necessary information, including the Claims Administrator's determination on review, will be transmitted by telephone, facsimile, email, or other similarly expeditious methods.

Notice of Determination on Appeal
Timing of Notice of Determination on Appeal
Pre-Service Claim
If you appeal the initial denial of a Pre-Service Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) within a reasonable period of time considering the medical circumstances, but not later than 30 days after receipt of the appeal or, if the Benefit Program allows for a second level of appeal, 15 days after receipt of the appeal.

Urgent Care Claim
If you appeal the initial denial of an Urgent Care Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) as soon as possible taking into account the medical circumstances, but no later than 72 hours after receipt of the appeal.

Post-Service Claim
If you appeal the initial denial of a Post-Service Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) within a reasonable period of time, but not later than 60 days after receipt of the appeal or, if the Benefit Program requires two levels of appeal, 30 days after receipt of the appeal.

If your Claim is for benefits conditioned upon a determination of disability, you will be notified of the determination on review (whether adverse or not) within a reasonable period of time, but not later than 45 days after receipt of the appeal.

Form and Content of Notice of Denial on Appeal

If your Claim is denied upon appeal, in whole or in part, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its determination in a culturally and linguistically appropriate manner. The notice of denial on appeal will:

- provide information to help you identify the Claim including, upon request and when applicable, the diagnosis and treatment codes and the meanings of those codes;

- inform you of the specific reasons for the denial and include any denial code and its corresponding meaning;

- provide you with a description of the Plan's standard, if any, used in denying the Claim;

- inform you of the specific Plan provisions on which the denial is based;

- provide an explanation of additional internal levels of appeal and external review that the Plan makes available, if any, including information about how to initiate an appeal and the applicable time limits;

- contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the decision to deny your Claim (in whole or in part);

- describe any rule, standard, guideline, protocol, or similar document or criteria relied on in denying the Claim on appeal; or include a statement that the rule, standard, guideline, protocol, or similar document or criteria was relied on and that a copy of it may be obtained at no charge upon request;

- contain a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures;

- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, explain the scientific or clinical judgement for the denial, or include a statement that an explanation will be provided free of charge upon request;

- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

- provide contact information for an office of health insurance consumer assistance or a health insurance ombudsman program, if such a service has been established in your state.

Unless the Benefit Program provides for a second level of appeal, the decision of the Claims Administrator on appeal is final, subject to external review (as described below) or the order of a federal court in a civil action.

Second Level of Appeal
If you receive a Notice of Denial on Appeal under the Dental Program and you wish to challenge the denial, you must file a second appeal with the Claims Administrators within 60 days of receiving the Notice of Denial on Appeal or, if later, 180 days of receiving the Notice of Initial Claim Denial.

Urgent Care Claims are not subject to this second level of appeal.

The process for a second-level appeal is the same as for a first-level appeal. The decision of the Claims Administrator on a second appeal is final, subject to independent external review (as described below) or the order of a federal court in a civil action.

External Review
Under certain circumstances described below, your Claim under the Medical Program may be eligible for external review by an independent reviewing organization ("**IRO**"). This external review procedure is voluntary and you are not required to use it before filing a civil action in court.

The IRO will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. After reviewing all of the information available to you and the Plan, the IRO will recommend whether the Plan should uphold or reverse the Claim Administrator's final determination of the Claim. The IRO's decision is binding on the Plan and you, except to the extent that other remedies are available under state or federal law.

Standard Procedures for External Review
If you have exhausted the Benefit Program's required appeal procedures and your Claim under the Medical Program was denied because of a medical judgment (such as medical necessity, appropriateness, health care setting, level of care or effectiveness) or a rescission of coverage, you have the right to request an external review. Claims regarding plan eligibility and contractual or legal interpretations of the Plan are not eligible for external review.

Request for External Review
If you decide to request an external review, you must submit a written request to the Claims Administrator within four months of the date of your final notice of denial on appeal. The final notice of denial on appeal will contain an explanation of how to make this request.

Preliminary Review
Upon receipt of your request, the Claims Administrator will have five business days to perform a preliminary review and determine whether your Claim is eligible for external review. If your request is incomplete, you will be permitted to submit the missing information within the original 4-month filing period or, if that time period has already expired, 48 hours from your receipt of the notice that your request is incomplete.

External Review
If the Claims Administrator determines that your Claim is eligible for external review, it will be assigned to an IRO and all documents and information considered in making the benefit determination will be forwarded to the IRO within five business days. You will receive a notice that your Claim has been accepted for external review and you will be given 10 days to submit

any additional information relevant to your Claim. You will receive the IRO's final decision within 45 days of receipt of your request for external review.

Expedited External Review
You can request an expedited external review of your Claim if you have:

- filed a request for expedited internal appeal but your Claim involves a medical condition for which the timeframe for completion of that appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function; or

- exhausted the required internal appeal procedures and the Claim involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or jeopardize your ability to regain maximum function; or if the Claim concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services, and you have not been discharged from the facility.

A request for an expedited external appeal may be submitted orally or in writing, and all necessary information may be provided by telephone, facsimile, or any other similarly expeditious method. The process is substantially the same as the standard procedures described above except that the Claims Administrator's preliminary review will be performed immediately, all documentation and information considered in making the benefit determination will be transmitted to the IRO electronically or by telephone or facsimile or other available expeditious method, and the IRO's notice of final determination will be issued as expeditiously as the circumstances require, but no later than 72 hours after the IRO receives your request for expedited external review. If the notice is given orally, you will receive a written confirmation of the determination within 48 hours of the date of the oral notice.

If the Claim involves experimental or investigational treatments, the IRO will ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.

Filing Civil Action
If you have exhausted the required appeal procedures and your Claim is denied in whole or in part, you will have the right to file a civil action in court. If you do not exhaust the required appeal procedures, the Claim you file in court will be subject to dismissal. Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date on which you receive the final notice of denial on appeal.

Failure of Claims Administrator to Follow Procedures
If the Claims Administrator fails to comply with any of the required deadlines or fails to inform you adequately of your procedural rights, you may treat the Benefit Program's claims procedures as having been completed and immediately seek an external review or file a civil action in court.

Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date you knew, or should have known, of the material failure to comply with these procedures.

Claims Under Life/AD&D Insurance, Voluntary Benefits, and Business Travel Accident Insurance Programs

This section describes the procedures for filing and processing most Claims under the Life/AD&D Insurance, Voluntary Benefits, and Business Travel Accident Insurance Programs. If your Claim is for a benefit conditioned upon the Claims Administrator's determination of a disability, see "Claims Under the Short-Term Disability and Long-Term Disability Programs and Claims Under Other Benefit Programs for Benefits Conditioned Upon the Claims Administrator's Determination of Disability" for additional requirement that may apply.

Filing a Claim

To file a Claim under the Life/AD&D Insurance, Voluntary Benefits, and Business Travel Accident Insurance Programs, you must send a completed Claim form, and any materials or documentation required by the form, to the Claims Administrator at the address found in the Benefit Program & On-Site Medical Health Centers Information Chart. You may obtain a Claim form from the Plan Administrator or the Claims Administrator.

Unless otherwise specified in the applicable Insurance Contracts or Booklets, Claims under the Life/AD&D Insurance, Voluntary Benefits, and Business Travel Accident Insurance Programs must be submitted within 12 months of the date of the event giving rise to the Claim.

Notice of Initial Claim Denial

Timing of Notice of Initial Claim Denial

If your Claim is denied, in whole or in part, the Claims Administrator will notify you within a reasonable period of time (but not later than 90 days) after receipt of your Claim. An extension of up to 90 days is permitted if the Claims Administrator decides that special circumstances require the extension. You will receive written notice of the extension before the end of the initial determination period, including an explanation of the circumstances requiring the extension and the date by which the Claims Administrator expects to make its decision. If an extension is required because there is information missing from your Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Form and Content of Notice of Initial Claim Denial

Any adverse benefit determination, including any denial, reduction, or termination, in whole or part, of the benefit for which you filed a Claim, or any rescission of coverage, is a Claim denial. This includes any determination based on eligibility.

If your initial Claim is denied in whole or in part, or if your coverage is rescinded or terminated for cause, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its determination. This notice of claim denial will:

- inform you of the specific reasons for the denial of your initial Claim;
- inform you of the pertinent Plan provisions on which the denial is based;
- describe any additional materials necessary to perfect your Claim, and explain why this material is necessary; and

- include an explanation of the Plan's appeal procedures, including information about how to initiate an appeal and the applicable time limits; and a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures.

Filing an Appeal
If you receive a notice of initial claim denial and you wish to challenge the denial, you must file an appeal with the Claims Administrator within 60 days of receipt of the notice. Your appeal must be in writing and transmitted either by mail or a reasonably available electronic media. Your appeal must explain why you think your Claim should not have been denied and include any additional information, materials, or documentation supporting your Claim. You may also submit written comments, documents, records, and other information relating to your Claim. Upon request and free of charge, you will be provided with reasonable access to, and copies of, all documents, records and other information relevant to your Claim.

Notice of Determination on Appeal
Timing of Notice of Determination on Appeal
If you appeal the initial denial of your Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) within a reasonable period of time, but not later than 60 days after receipt of the appeal. An extension of up to 60 days is permitted if the Claims Administrator decides that special circumstances require the extension. You will receive written notice of the extension before the end of the initial determination period, including an explanation of the circumstances requiring the extension and the date by which the Claims Administrator expects to make its decision. If an extension is required because there is information missing from your Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Form and Content of Notice of Denial on Appeal
If your Claim is denied upon appeal, in whole or in part, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its denial in a culturally and linguistically appropriate manner. This notice of denial on appeal will:

- inform you of the specific reasons for the denial;

- inform you of the specific Plan provisions on which the denial is based;

- provide an explanation of additional levels of appeal that the Plan makes available, if any, including information about how to initiate an appeal and the applicable time limits;

- contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the decision to deny your Claim (in whole or in part);

- contain a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures.

The decision of the Claims Administrator on appeal is final, subject to the order of a federal court in a civil action.>>

Filing Civil Action
If you have exhausted the required appeal procedures and your Claim is denied in whole or in part, you will have the right to file a civil action in court. If you do not exhaust the required appeal procedures, the Claim you file in court will be subject to dismissal. Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date on which you receive the final notice of denial on appeal.

Failure of Claims Administrator to Follow Procedures
If the Claims Administrator fails to comply with any of the required deadlines or fails to inform you adequately of your procedural rights, you may treat a Benefit Program's claims procedures as having been completed and immediately file a civil action in court.

Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date you knew, or should have known, of the material failure to comply with these procedures.

Claims Under the Short-Term Disability and Long-Term Disability Programs and Claims Under Other Benefit Programs for Benefits Conditioned Upon the Claims Administrator's Determination of Disability
This section describes the procedures for filing and processing Claims under the Short-Term Disability and Long-Term Disability Programs. These rules also apply to Claims under other Benefit Programs if the Claim is for benefits that are conditioned upon the Claims Administrator's determination of disability.

Filing a Claim
To file a Claim for benefits under the Short-Term Disability or Long-Term Disability Program, you must send a completed Claim form, and any materials or documentation required by the form, to the Claims Administrator at the address found in the Benefit Program & On-Site Medical Health Centers Information Chart. You may obtain a Claim form from the Plan Administrator or the Claims Administrator. Unless otherwise specified in the applicable Insurance Contracts or Booklets, Claims under the Short-Term Disability or Long-Term Disability Program must be submitted within 12 months of the date of the event giving rise to the Claim.

To file a Claim for benefits conditioned upon a determination of disability under any other Benefit Program, follow the procedures described above for the applicable Program.

Notice of Initial Claim Denial
Timing of Notice of Initial Claim Denial
If your Claim is denied, the Claims Administrator will notify you within a reasonable period of time (but not later than 45 days) after receipt of your Claim. The determination period may be extended by 30 days if the Claims Administrator decides it is necessary due to matters beyond its control. If an extension is required, you will receive notice prior to the end of the initial determination period. A second 30-day extension may be taken by the Claims Administrator so long as you are again notified before the end of the first 30-day extension period. The notice of extension will:

- explain the standards on which entitlement to a benefit is based;
- indicate the unresolved issues that prevent a decision on the Claim;
- describe the additional information that is needed to resolve those issues;
- include the date by which the Claims Administrator expects to make its decision.

If the Claims Administrator requests additional information, you will be allowed a reasonable period of time (at least 45 days) to submit that information before the Claims Administrator proceeds to make its decision.

Form and Content of Notice of Initial Claim Denial
Any adverse benefit determination, including any denial, reduction, or termination, in whole or part, of the benefit for which you filed a Claim, or any rescission of coverage, is a Claim denial. This includes any determination based on eligibility.

If your initial Claim is denied in whole or in part, or if your coverage is rescinded or terminated for cause, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its determination in a culturally and linguistically appropriate manner. The notice of initial claim denial will:

- inform you of the specific reasons for the denial of your initial Claim;
- inform you of the pertinent Plan provisions on which the denial is based;
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, explain the scientific or clinical judgment for the denial, or include a statement that an explanation will be provided free of charge upon request;
- describe any additional materials necessary to perfect your Claim, and explain why this material is necessary;
- include an explanation of the Plan's appeal procedures, including information about how to initiate an appeal and the applicable time limits; and a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures;
- include an explanation of the basis for disagreeing with, or not following: the views presented by you of health care professionals treating you or vocational professionals evaluating your Claim; the views of medical or vocational experts obtained by the plan even if the views were not relied upon in making the decision to deny your Claim; a disability determination made by the Social Security Administration;
- describe any rule, standard, guideline, protocol, or similar document or criteria relied on in making the initial determination; or include a statement that one does not exist; and

- include a statement that you are entitled to receive, free of charge and on request, reasonable access to, and copies of, all document, records, and other information relevant to your Claim.

Filing an Appeal
If you receive a notice of initial claim denial and you wish to challenge the denial, you must file an appeal with the Claims Administrator within 180 days of receipt of the notice of initial claim denial. Your appeal must be in writing and transmitted either by mail or a reasonably available electronic media. Your appeal must explain why you think your Claim should not have been denied and include any additional information, materials, or documentation supporting your Claim. You may also submit written comments, documents, records, and other information relating to your Claim. Upon request and free of charge, you will be provided with reasonable access to, and copies of, all documents, records and other information relevant to your Claim.

Review of Appeal
The persons reviewing your appeal will grant no deference to the original Claim denial or the first-level appeal decision, if applicable, but will assess the information you provide as if they were looking at the Claim for the first time. Also, the persons reviewing your appeal will not be the same persons who made the initial decision or reviewed the prior appeal (if any), nor will they be subordinates of those individuals. Upon request and free of charge, you will also be provided reasonable access to and copies of, all documents, records, and other information relevant to your Claim.

If the initial Claim denial or the first-level appeal of your Claim, if applicable, is based on medical judgment, the Claims Administrator must consult with an expert in the appropriate field when reviewing the Claim. The expert will not be someone who was consulted in the initial review of your Claim or a subordinate of anyone consulted in that review. The identity of any expert consulted, whether or not his or her opinion is relied on in determining your Claim, will be retained as information relevant to your Claim.

Notice of Determination on Appeal
Timing of Notice of Determination on Appeal
If you appeal the initial denial of your Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) within a reasonable period of time, but not later than 45 days after receipt of the appeal. An extension of up to 45 days is permitted if the Claims Administrator decides that special circumstances require the extension. You will receive written notice of the extension before the end of the initial determination period, including an explanation of the circumstances requiring the extension and the date by which the Claims Administrator expects to make its decision. If an extension is required because there is information missing from your Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Form and Content of Notice of Denial on Appeal
If your Claim is denied upon appeal, in whole or in part, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its denial in a culturally and linguistically appropriate manner. The notice of denial on appeal will:

- inform you of the specific reasons for the denial;
- provide you with a description of the Plan's standard, if any, used in denying the Claim;
- inform you of the specific Plan provisions on which the denial is based;
- provide an explanation of additional levels of appeal that the Plan makes available, if any, including information about how to initiate an appeal and the applicable time limits;
- contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the decision to deny your Claim (in whole or in part);
- contain a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures and a description of any time limitations that apply to that right, including the calendar date on which the limitations expire;
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, explain the scientific or clinical judgement for the denial, or include a statement that an explanation will be provided free of charge upon request;
- an explanation of the basis for disagreeing with, or not following: the views presented by you of health care professionals treating you or vocational professionals evaluating your Claim; the views of medical or vocational experts obtained by the plan even if the views were not relied upon in making the decision to deny your Claim; a disability determination made by the Social Security Administration; and
- a description of any rule, standard, guideline, protocol, or similar document or criteria relied on in making the initial determination; or a statement that one does not exist.

Before the Claims Administrator makes its decision, the Plan will notify you of any additional grounds for denying your Claim and provide you with an opportunity to present additional evidence in response. This evidence will be provided as soon as possible and sufficiently in advance of the date the Plan must provide notice of its decision on appeal.

Unless the Benefit Program requires a second level of appeal, the decision of the Claims Administrator on appeal is final, subject to the order of a federal court in a civil action.

Second Level of Appeal

If you receive a notice of denial on appeal for a Claim under the Short-Term Disability Program, or a Claim for a benefit conditioned upon a determination of disability under a Benefit Program that requires a second level of appeal, and you wish to challenge the denial, you must file a second appeal with the Claims Administrators within 60 days of receiving the Notice of Disability Claim Denial on Appeal or, if later, 180 days of receiving the Notice of Initial Disability Claim Denial.

The process for a second-level appeal is the same as for a first-level appeal. The decision of the Claims Administrator on a second appeal is final, subject to the order of a federal court in a civil action.

Filing Civil Action
If you have exhausted the required appeal procedures and your Claim is denied in whole or in part, you will have the right to file a civil action in court. If you do not exhaust the required appeal procedures, the Claim you file in court will be subject to dismissal. Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date on which you receive the final notice of denial on appeal.

Failure of Claims Administrator to Follow Procedures
If the Claims Administrator fails to comply with any of the required deadlines or fails to inform you adequately of your procedural rights, you may treat a Benefit Program's claims procedures as having been completed and immediately file a civil action in court.

Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date you knew, or should have known, of the material failure to comply with these procedures.

Claims Under Day Care FSA Program
Filing a Claim
Claims for reimbursement of Eligible Dependent Care Expenses under the Day Care FSA Program must be submitted on Claim forms available from the Plan Administrator. All Claims must:

- Be for a paid expense incurred during the Plan Year; and
- Include:
    - Amount, date, and nature of the expense;
    - Name, address, and the federal taxpayer identification number or employer identification number of the person, organization, or entity to which the expense was or is to be paid;
    - Name of the person for whom the expense was incurred, and the relationship of that person to you;
    - Amount recovered or recoverable from any other source with respect to the expense;
    - Written evidence from an independent third party stating that the expense has been incurred, the amount of the expense (e.g., bills, invoices, receipts, or other writings showing the amount of the expense); and
    - Any other information deemed necessary by the Claims Administrator in order to make a reasonable determination that the expense is reimbursable.

To obtain reimbursement of Eligible Dependent Care Expenses incurred during a Plan Year, you must submit a Claim to the Claims Administrator within 90 days of the end of the Plan Year.

If the Plan Sponsor terminates the Benefit Program, or your Company terminates its participation in the Benefit Program, you will have 90 days from the date of termination or 90 days from the date your Company terminates its participation to submit your final Claims.

Small claims may be held until they reach a reasonable threshold amount to be established by the Claims Administrator.

Notice of Initial Claim Denial

If your Claim is denied, the Claims Administrator will notify you within a reasonable period of time, but not later than 30 days after receipt of the Claim, or 45 days if the Claims Administrator determines an extension is necessary due to matters beyond the control of the Plan and notifies you within the original 30-day period of the reason for the extension and date by which the determination is intended to be made. If the extension is necessary because you failed to submit a complete Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Filing an Appeal

If you receive a notice of initial claim denial and you wish to challenge the denial, you must file an appeal with the Claims Administrator within 60 days of receipt of the notice. Your appeal must be in writing and transmitted either by mail or a reasonably available electronic media. Your appeal must explain why you think your Claim should not have been denied and include any additional information, materials, or documentation supporting your Claim. You may also submit written comments, documents, records, and other information relating to your Claim. Upon request and free of charge, you will be provided with reasonable access to, and copies of, all documents, records and other information relevant to your Claim.

Notice of Determination on Appeal

Timing of Notice of Determination on Appeal

If you appeal the initial denial of your Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) within a reasonable period of time, but not later than 60 days after receipt of the appeal. An extension of up to 60 days is permitted if the Claims Administrator decides that special circumstances require the extension. You will receive written notice of the extension before the end of the initial determination period, including an explanation of the circumstances requiring the extension and the date by which the Claims Administrator expects to make its decision. If an extension is required because there is information missing from your Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Form and Content of Notice of Denial on Appeal

If your Claim is denied upon appeal, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its denial, including the specific reasons for the denial on appeal.

Filing Civil Action
If you have exhausted the required appeal procedures and your Claim is denied in whole or in part, you will have the right to file a civil action in court. If you do not exhaust the required appeal procedures, the Claim you file in court may be subject to dismissal. Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date on which you receive the final notice of denial on appeal.

Claims Under HSA Contributions Program
Claims for payment or reimbursement of expenses under your HSA are governed by the terms and conditions of your custodial agreement. Refer to your custodial agreement or contact your HSA custodian for applicable claims procedures.

For Claims related to your eligibility for the HSA Contributions Program, see "Claims Based Solely on Eligibility to Participate in Plan or Benefit Program" below.

Claims Under Pre-Tax Payment Program
You are not required to file a Claim for benefits under the Pre-Tax Payment Program. Benefits are provided automatically once you are enrolled in the Program.

For Claims related to your eligibility for the Pre-Tax Payment Program, see "Claims Based Solely on Eligibility to Participate in Plan or Benefit Program" below.

Claims Based Solely on Eligibility to Participate in Plan or Benefit Program
Filing a Claim
If for any reason you believe you have been improperly excluded from the Plan or from any of the Plan's Benefit Programs, you may file a formal Claim in writing to the Plan Administrator. Be sure to state:

- Reason you think you should be entitled to participate in the Plan or in a particular Benefit Program;
- Reason you think you have not been permitted to participate; and
- Your name and Social Security number.

This procedure only applies to a Claim that deals solely with eligibility to participate in the Plan or a particular Benefit Program. It will not apply to eligibility determinations that are linked to a Claim for a specific benefit under a particular Benefit Program. In those instances, your Claim will be decided under the procedures that apply to the specific benefit you are seeking.

Initial Claim Decision
Notice of the decision on your Claim to participate will be issued within a reasonable period of time, but not later than 30 days after receipt of the Claim, or 45 days if the Plan Administrator determines an extension is necessary due to matters beyond the control of the Plan and notifies you within the original 30-day period of the reason for the extension and date by which the determination is intended to be made. If the extension is necessary because you failed to submit a complete Claim, the notice will describe the missing information and you will be given at least

45 days from receipt of the notice to provide that information before the Plan Administrator makes its determination.

Claim Review Procedures
If your Claim for eligibility to participate in the Plan or one of its Benefits Programs is denied, in whole or in part, and you disagree with this decision, you must make a written appeal to the Plan Administrator for a review of the denial of your Claim within 60 days of the notice of denial.

Upon request and free of charge, you may review and receive copies of the documents, records, and other information relevant to your Claim to participate. You may also submit written comments, documents, records, and other information relating to your appeal to the Plan Administrator.

The review on your appeal will take into account all comments, documents, records, and other information submitted by you relating to your appeal, even if that information was not submitted or considered in the initial decision of your Claim. The Plan Administrator will make its decision on your appeal within a reasonable time, but no later than 60 days from receipt of the appeal. An extension of up to 60 days is permitted if the Claims Administrator decides that special circumstances require the extension. You will receive written notice of the extension before the end of the initial determination period, including an explanation of the circumstances requiring the extension and the date by which the Claims Administrator expects to make its decision. If an extension is required because there is information missing from your Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

SPECIAL RULES FOR THE HEALTH CARE PROGRAMS

General Exclusions
No benefits are payable for any expense or portion of an expense under the Medical, Dental, Vision, and Health Care FSA Programs:

- due to an injury or illness that is covered under workers compensation insurance;
- for any expense where there is no legal obligation or financial liability to pay, or where charges would not be made if there were no coverage under this Plan;
- for expenses for services, care or supplies that are rendered or received prior to or after any period of coverage under this Plan, except as specifically provided under this Plan;
- for services or treatment given by an immediate family member (parent, grandparent, Spouse, Child, grandchild or sibling) or a person residing in the same household as the patient;
- for expenses that the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government; or
- for benefits that are provided under Medicare, except as provided in the section titled "Coordination with Medicare."

Coordination Of Benefits
The insured Benefit Programs will be coordinated in accordance with the applicable provision of the policies and Booklets provided by the insurer(s) or HMO(s).

With respect to the Self-funded benefits, the Plan will coordinate with:

- another group health plan (including any employer-sponsored welfare benefit plan, whether or not insured, that provides medical or dental coverage, including prescription drugs), such as insurance provided by a Spouse's employer;

- automobile accident insurance; and

- money you or your Covered Dependent could receive from another person or entity who caused the injuries on account of which a Claim was made.

When the Plan coordinates benefits, one source of benefits will be "**Primary**" (that is, it will pay before the other source). The other source will be "**Secondary**" (that is, it will pay after the source of benefits that is Primary).

When the Plan is Primary, it will pay benefits as if there were no other source of benefits. But if the Plan is Secondary, it will initially deny the claim until other coverage that is primary has paid. Once other coverage has paid, the Plan will calculate what it would pay in the absence of any other source of benefits, and then will subtract from that amount the amount paid by the other source. The Plan will pay that difference so that the Participant will receive the full amount of benefits payable under the Plan. This Plan will not, however, pay more than it would have if it were the only source of benefits.

Coordination With Other Group Health Plans
If you and/or your Covered Dependent incur an expense that would be paid by two or more group health plans, the group health plan with the highest priority is Primary and will pay first. The other group health plan is Secondary and will pay next.

Benefits will be paid as follows:

First: A group health plan without a coordination of benefits provision will pay.

Second: Then a group health plan covering the patient as an employee, rather than as a dependent, will pay.

Third: Then in the case of a group health plan covering a patient who is a dependent and a minor Child of divorced or legally separated parents:

- if a divorce decree or separation agreement makes a parent responsible for a Child's health expenses, that parent's group health plan (that also covers the Child) will pay;

- then a group health plan that covers the Child as a dependent of a custodial parent will pay;

- then a group health plan that covers the Child as a dependent of the spouse of the custodial parent will pay;

- then a group health plan that covers the Child as a dependent of the non-custodial parent will pay.

Fourth: Then in the case of a group health plan covering a patient who is a dependent and minor child of married parents, the group health plan of the parent whose birthday occurs earlier in the year will pay.

Fifth: Then in the case of a group health plan covering a patient who is a dependent and minor child of married parents, the group health plan of the parent whose birthday occurs later in the year will pay.

Sixth: Then the group health plan that has covered the patient for the longer period of time will pay.

Seventh: Then any other group health plan will pay.

If two or more group health plans have the same priority, they will each pay pro-rata. There are some special rules that have precedence over the above priorities.

- COBRA coverage is always Secondary to any other group health plan,

- Coverage provided by virtue of being a retired or laid-off employee or an employee on a leave of absence is always secondary to coverage provided by virtue of that individual being an active employee.

Coordination With Automobile Accident Insurance
The Plan coordinates payment of its Self-funded health care benefits on a Secondary basis. Any state insurance law that purports to require that the Plan pay Primary or that does not allow the Plan to subrogate or recover its payments is preempted by ERISA. This means that even if you are covered under an automobile insurance policy that makes "other health coverage" Primary, the Plan will still pay Secondary for those benefits that are Self-funded.

You are considered covered under an automobile insurance policy if you are:

- an owner or principal named insured under the policy;

- a family member of a person insured under the policy; or

- a person who would be eligible for medical expense benefits under an automobile insurance policy if this Plan did not exist.

If you do not have automobile insurance coverage even though you are legally required to do so, the Plan will not pay more benefits than it would have paid if you had purchased standard automobile insurance coverage.

Coordination With Medicare
The general rule is that the Plan will be Secondary to Medicare in all circumstances where federal law does not require the Plan to be Primary. If you are covered under the Medical Benefit Program as an active Associate and you or your Spouse are over 65 years old and eligible for Medicare, you may reject coverage in this Plan and rely on Medicare as your sole source of coverage. If you do not reject coverage under this Plan, you will have coverage under both this Plan and Medicare, and Medicare will be Secondary. Medicare is also available for certain people who have not yet reached the age of 65, but who have received Social Security disability benefits for at least 24 months. When Medicare is available in those situations, the Plan will be Primary for you and your Covered Dependents as long as you are in current employment status; otherwise the Plan will be Secondary.

Medicare is also available to individuals who have been under treatment for end-stage renal disease. The Plan will be Primary to Medicare for a covered individual who qualifies for Medicare benefits because of end-stage renal disease for the coordination period set forth in the Medicare secondary payer provisions of the Social Security Act. After the coordination period ends, the Plan will be Secondary.

It is your responsibility to apply for Medicare benefits that are available. If Medicare is Primary under these rules, the Plan will calculate the benefits it provides as if you were enrolled in Medicare, regardless of whether you have applied.

Coordination With CHIP Coverage
The Plan will be considered primary to any CHIP coverage that supplements this Plan.

Coordination With Third Parties
If a third party negligently or tortiously causes a health problem on account of which you have Incurred medical expenses, the Plan is Secondary to the third party's liability to you. If benefits are available under any insurance policy as a result of this negligent or tortious conduct, the Plan is Secondary to those benefits.

Facility Of Payment
If an expense or benefit that should have been paid by the Plan is paid by another person or entity, the Plan may pay to that person or entity any amount that it considers necessary to satisfy the intent of the Plan's coordination provisions. The Plan will then have no further liability for those expenses or benefits.

The Plan will not pay any expense or benefit that has actually been paid by another source, even if that other source is Secondary to the Plan, unless that source files a claim for reimbursement. If the other source files a claim for reimbursement, the Facility of Payment provision of this Plan applies.

Subrogation/Right Of Recovery

If you or your Covered Dependents incur medical expenses for which another party may be responsible, the Plan has a right to recover benefits paid by the Plan for such expenses. The Plan has an equitable right to seek reimbursement from any payments that you or your Covered Dependents receive from such party, or the Plan may "step into the shoes" of yourself or your Covered Dependent, or your successors in interest, to bring a subrogation action against any third party that may be responsible for paying these costs. This right exists until the Plan has been reimbursed in full for the benefits it has paid and the expenses and attorney fees the Plan has incurred in enforcing its rights.

For those benefits provided through an insurance program, more information about these subrogation and reimbursement rights is explained in the various insurance policies and booklets provided by the insurance companies and HMOs.

When you and your Covered Dependents accept benefits under the self-insured programs that are part of this Plan, you assign to the Plan, or transfer to the Plan, all rights of recovery from any other party, to the fullest extent permitted by law. The Plan will be subrogated to and may bring any claim you or your Covered Dependents may have against the other party (or its insurer). You may not assign your claims to any other person without permission of the Plan. The Plan will have a first priority lien on any recovery for the total amount it has paid, as well as for any expenses or attorneys' fees incurred in enforcing the Plan's rights. The Plan may withhold payment of benefits when it appears that another party may be liable for the expenses until the liability is legally determined.

If you or your Covered Dependents receive any funds from any person who may have a responsibility to pay expenses covered by the Plan, the Plan has the right to be reimbursed from your total recovery before any amounts, including expenses or attorneys' fees, are deducted, whether or not the recovery is specifically for medical payments, and regardless of how the proceeds are characterized or the source of the recovery. This is a right of first reimbursement, and the "make whole" rule or "common fund" rule will not apply.

Without limiting the Plan's right to reimbursement or subrogation, these rights apply to any judgment, settlement or payment made or to be made because of an accident or malpractice, including but not limited to payments made by other insurance of any kind. The Plan will not pay, offset any recovery, or in any way be responsible for any fee or costs associated with pursuing a claim unless the Plan agrees to do so in writing.

You and your Covered Dependents must cooperate fully with the Plan Administrator to protect the Plan's right of reduction, recovery, reimbursement or subrogation and must sign any reimbursement or subrogation agreement or other document that may be requested by the Plan Administrator, although the Plan may exercise its rights under this section whether or not any such agreement is requested or signed by you. You and your Covered Dependents are responsible for notifying the Plan in writing of any claim you may have against another party who may be responsible for benefits paid under this Plan.

If you, your agent, a trust, or any other person or entity receives any proceeds of settlement or judgment on behalf of you or your Covered Dependent, and if the Plan has a right to any portion of those proceeds, you, your agent, or the third party must hold those proceeds in trust for the

Plan. The Plan may recover any expenses it incurs because you or your Covered Dependents failed to cooperate in enforcing the Plan's rights under this section. If you or your Covered Dependents do not comply with this section, your right to benefits under the Plan may be forfeited.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("**COBRA**") gives you and your Covered Dependents the right to continue coverage under the Medical, Dental, Vision, EAP, Health Care FSA, On-Site Medical, and Healthy Horizons Programs beyond the time the coverage would normally end ("**Continuation Coverage**"), under certain circumstances. COBRA Continuation Coverage can become available to you and your Covered Dependents when you or they would otherwise lose group health coverage. This section generally explains COBRA Continuation Coverage, when it may become available to you and your Covered Dependents, and what you need to protect your right to receive it.

You may have other, more affordable options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees. When deciding whether to elect COBRA Continuation Coverage, you should investigate these other options.

COBRA Continuation Coverage for the Plan is administered by the "**COBRA Administrator**," whose name, address, and phone number can be found in the Benefit Program & On-Site Medical Health Centers Information Chart.

Qualifying Events

COBRA Continuation Coverage is a continuation of coverage under the Medical, Dental, Vision, EAP, Health Care FSA, On-Site Medical, and Healthy Horizons Programs when coverage would otherwise end on account of a life event known as a "**Qualifying Event**." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a Qualified Beneficiary. A "**Qualified Beneficiary**" is someone who will lose coverage under the Plan because of a Qualifying Event.

You will become a Qualified Beneficiary if you will lose your coverage under the Plan because either one of the following Qualifying Events happens:

- Your hours of work are reduced or you move to a position with the Company where you are not eligible to participate in the Plan.

- Your employment ends for any reason other than your gross misconduct.

Your Spouse will become a Qualified Beneficiary if coverage is lost because any one or more of the following Qualifying Events happens:

- You die.

- You are divorced or legally separated from your Spouse.
- Your hours of work are reduced or you move to a position with the Company where you are not eligible to participate in the Plan.
- Your employment ends for any reason other than your gross misconduct.
- You become entitled to Medicare benefits (under Part A, Part B, or both).

Your Covered Dependent Child will become a Qualified Beneficiary if he or she loses coverage under the Plan because any one of the following Qualifying Events happens:

- You die.
- You are divorced or legally separated from your Spouse.
- Your hours of work are reduced or you move to a position with the Company where you are not eligible to participate in the Plan.
- Your employment ends for any reason other than your gross misconduct.
- You become entitled to Medicare benefits (under Part A, Part B, or both).
- Your Child stops being an Eligible Dependent.

Notice Of Qualifying Event Required
The Plan offers COBRA Continuation Coverage to Qualified Beneficiaries only after the COBRA Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the reduction of your hours or end of your employment, your death, commencement of a proceeding in bankruptcy by the Company or your becoming entitled to Medicare benefits (under Part A, Part B, or both), the Company must notify the COBRA Administrator of the Qualifying Event.

For the other Qualifying Events (your divorce or legal separation, or your Child's losing eligibility for coverage as a Covered Dependent), you must notify the COBRA Administrator within 60 days after the Qualifying Event occurs. You must provide written notice of the Qualifying Event to the COBRA Administrator. Your notice must include: the name of the Associate or former Associate who is or was a Plan Participant, a description of the Qualifying Event, the date of the Qualifying Event, any documents or materials relevant to the Qualifying Event, and the name(s), address(es), and Social Security number(s) of the Covered Dependent(s) affected by the Qualifying Event. Failure to notify the COBRA Administrator in a timely manner will mean that neither you nor your Covered Dependents will be able to elect COBRA Continuation Coverage for these Qualifying Events.

Electing COBRA Continuation Coverage
Once the COBRA Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. To elect Continuation

Coverage, you must complete the election form and send it in according to the directions on the form. Each Qualified Beneficiary has a separate right to elect COBRA Continuation Coverage. For example, your Spouse may elect coverage even if you do not. COBRA Continuation Coverage may be elected for only one, several, or for all Covered Dependents who are Qualified Beneficiaries. A parent may elect or reject Continuation Coverage for any minor Children. You and your Spouse may elect Continuation Coverage for each other, but cannot reject coverage for the other person. After you have submitted your election forms, if it is determined that you or a Covered Dependent is not entitled to Continuation Coverage, you will be provided with a written explanation of why the election of Continuation Coverage could not be honored.

In considering whether to elect COBRA Continuation Coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible, such as a plan sponsored by your Spouse's employer, within 30 days after your group health plan coverage ends because of the Qualifying Events listed above. You will also have the same special enrollment right at the end of COBRA Continuation Coverage if you elect COBRA Continuation Coverage for the maximum time available to you.

Cost Of COBRA Continuation Coverage

Generally, each Qualified Beneficiary must pay the entire cost of COBRA Continuation Coverage. The cost cannot exceed 102% (or in the case of an extension due to a disability, 150%) of the cost to the Plan for coverage of a similarly-situated Plan Participant and/or beneficiary who is not receiving COBRA Continuation Coverage. The cost for a similarly-situated Plan Participant or beneficiary includes both the employer and Associate contributions for coverage. The required payment for each COBRA Continuation period for each option will be described in the notice sent to you.

Paying For COBRA Continuation Coverage

First Payment For COBRA Continuation Coverage

If you elect COBRA Continuation Coverage, you do not have to send any payment with the election form. You must, however, make your first payment no later than 45 days after the date of your election. (This is the date the election notice is post-marked, if mailed.) If you miss this first payment date, you will lose all COBRA Continuation Coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your payment.

Periodic Payments For COBRA Continuation Coverage

After your first payment for COBRA Continuation Coverage, you will be required to make monthly payments for each subsequent coverage period. Each monthly payment for COBRA Continuation Coverage is due on the dates stated in the COBRA election forms sent to you. If you make a monthly payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods, but you are required to timely submit payment for COBRA continuation coverage even if you do not receive a periodic notice of payment due.

Grace Periods For Monthly Payments

Although monthly payments are due on the dates stated in the COBRA election forms, you will be given a grace period of 30 days after the first day of each coverage period to make each periodic payment. Your COBRA Continuation Coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a monthly payment before the end of the grace period for that coverage period, you will lose all rights to COBRA Continuation Coverage under the Plan retroactive to the date payment was due. If a partial premium payment is made that falls short of the current amount due by a minimal amount, you will be notified, and either the amount paid will be deemed payment in full for that period or you will be asked to pay the shortfall. If the notice says the shortfall must be paid and you do not pay within 30 days after the date the notice is received, COBRA Continuation Coverage will end retroactive to the date the shortfall payment was due.

Duration Of Coverage

COBRA Continuation Coverage for you and/or your Covered Dependents may continue:

- for 18 months when the Qualifying Event is the end of your employment or reduction in your hours of employment;
- 29 months when the Qualifying Event is your end of employment or reduction of your work hours and you or a Covered Dependent qualify for a disability extension (refer to "Disability" below) during the 18-month COBRA Continuation Coverage period;
- for your Covered Dependents for 36 months when the Qualifying Event is your divorce or legal separation, your death, your enrollment in Medicare (Part A or Part B) or a Child's loss of Eligible Dependent status; or
- for your Covered Dependents, when the Qualifying Event is your end of employment or reduction in your work hours, and you enrolled in Medicare fewer than 18 months before the Qualifying Event, for 36 months after the date you enrolled in Medicare. For example, if you enrolled in Medicare eight months before you terminated employment, Continuation Coverage for your Covered Dependents could last up to 36 months from the date you enrolled in Medicare, which is 28 months after the date of the Qualifying Event.

COBRA Continuation Coverage will be terminated before the end of the maximum period if:

- any required premium payment is not paid in full on time;
- after electing COBRA Continuation Coverage, a Qualified Beneficiary:
    - becomes covered under another employer's group health plan that does not impose any pre-existing condition exclusion for a Qualified Beneficiary's pre-existing condition; or
    - becomes enrolled in Medicare benefits, under Part A or Part B, or both; or
- the Company ceases to provide any group health plan for its Associates or employees.

COBRA Continuation Coverage also may be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving COBRA Continuation Coverage, such as fraud. If your period of COBRA Continuation Coverage is terminated for any reason before the end of your maximum period, you will be notified of the termination and provided with an explanation of why it was terminated.

Extending the Length of COBRA Continuation Coverage

There are two ways in which a COBRA Continuation Coverage period of less than 36 months may be extended: if a Qualified Beneficiary is disabled or a second Qualifying Event occurs. You must notify the Plan or COBRA Administrator in writing of a disability or second Qualifying Event in order to extend the period of COBRA Continuation Coverage. Your failure to provide notice of a disability or second Qualifying Event may affect the right to extend the period of COBRA Continuation Coverage.

Disability

If you or any Covered Dependent is determined by the Social Security Administration to be disabled and you notify the Plan or COBRA Administrator in a timely fashion, you and your entire family may be entitled to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability has to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage.

You or a Covered Dependent must notify the Plan or COBRA Administrator in writing on or before the 60th day after the latest of: (a) the date of the Social Security Administration's disability determination, (b) the date on which the employment-related Qualifying Event occurred, or (c) the date on which the Qualified Beneficiary lost Plan coverage but, in any event, before the end of the original 18-month COBRA Continuation Coverage period. This disability notice must include the name of the disabled person, the effective date of the Social Security Administration's disability determination, and any accompanying documentation.

Each Qualified Beneficiary who has elected COBRA Continuation Coverage on account of your employment-related Qualifying Event will be entitled to the 11-month disability extension as long as one of them qualifies for it. If the disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan or COBRA Administrator of that fact in writing on or before the 30th day following the Social Security Administration's determination. Coverage due to your initial employment-related Qualifying Event, or any subsequent Qualifying Event, may still be available if the maximum period for that COBRA Continuation Coverage has not expired as of the date a determination of "no longer disabled" is made.

Second Qualifying Event

If your Covered Dependents experience another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, your Covered Dependents can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the COBRA Administrator. This extension may be available to your Covered Dependents receiving COBRA Continuation Coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or get divorced or legally separated from your

Spouse, or your Child stops being an Eligible Dependent, but only if the event would have caused your Covered Dependent to lose coverage under the Plan had the first Qualifying Event not occurred.

You must notify the Plan or COBRA Administrator within 60 days after a second Qualifying Event occurs if you want to extend COBRA Continuation Coverage. Your notice must include: the name of the Associate or former Associate who is or was a Plan Participant; a description of the second Qualifying Event; and the name(s), address(es), and Social Security number(s) of the Covered Dependents involved in the second Qualifying Event. Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.

Special Rule for Health Care FSA Program

The COBRA Continuation Coverage you may elect with respect to the Health Care FSA Program is different from the COBRA Continuation Coverage you may elect with respect to other COBRA-eligible Benefit Programs offered by the Company.

First, COBRA Continuation Coverage for the Health Care FSA Program is only available until the end of the Plan Year in which the Qualifying Event occurs and may not be extended beyond that date.

Second, if you elect to receive COBRA Continuation Coverage under the Health Care FSA Program, you must pay the applicable premium, and the Company is entitled to add a 2% administration charge. If you will not be receiving any compensation that can be reduced under the Health Care FSA Program, you will be paying 102% premium on an after-tax basis for only 100% coverage. Thus, even though COBRA Continuation Coverage is available, you must decide if it is a justifiable option for you based on its cost to you.

Third, the Plan does not have to offer you COBRA Continuation Coverage for the Health Care FSA Program if, at the time of the Qualifying Event, the contribution you must pay for this coverage exceeds the maximum coverage remaining available to you for the Plan Year under the Health Care FSA Program. For example, if you terminate employment in March after electing to contribute $1,800 to the Health Care FSA Program and you have already submitted Claims totaling $1,000, then your remaining coverage would be $800, but your cost to keep this coverage would be $1,377 ($1,800 X 102% = $1,836/12 = $153/month X the 9 months remaining in Plan Year). In this case, you would not be entitled to COBRA Continuation Coverage under the Health Care FSA Program.

Questions About COBRA Continuation Coverage

If you have questions concerning the Plan or your COBRA Continuation Coverage rights, you should contact the COBRA Administrator. For more information about your rights under ERISA (including COBRA), HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("**EBSA**") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep The Plan Informed Of Any Changes Of Address

In order to protect your family's rights to COBRA Continuation Coverage, you should keep the Plan and COBRA Administrator informed of any changes in the addresses of family members.

Military Leave Continuation Coverage
If you are called to active duty in the United States Armed Forces, the Coast Guard, the National Guard or the Public Health Service, you will be offered, under the Uniformed Services Employment and Reemployment Act of 1994, as amended ("**USERRA**"), up to 24 months of continuation coverage. If your leave is less than 31 days, you will have to make the same contributions towards your coverage as do active Associates, but you cannot be required to contribute more than that amount. If your leave is longer than 31 days, you may be charged 102% of the cost for the coverage, including both employer and Associate contributions.

The maximum period for continuation coverage under USERRA is the lesser of (a) 24 months from the date your leave commences or (b) the period from the date your leave begins to the day after you fail to return to employment within the time allowed following discharge. For leaves less than 31 days, 1 day is allowed; for leaves 31-180 days, 14 days are allowed; for leaves longer than 180 days, 90 days are allowed. The continuation coverage mandated under USERRA is alternate coverage to that provided under COBRA, so the two coverage periods run concurrently, not consecutively. Eligibility for TRICARE (formerly CHAMPUS) or active duty military coverage will not terminate coverage under this continuation coverage.

HIPAA Privacy Rule
All definitions in the Health Insurance Portability and Accountability Act ("**HIPAA**") privacy regulations ("**Privacy Rules**") and security regulations ("**Security Rules**") are incorporated by reference into the Plan. If a term is not defined in the Privacy Rules or Security Rules, the term will have its generally accepted meaning.

Hybrid Entity
To the extent the Plan provides any non-health benefits (e.g., dependent care, disability, life insurance), only the health care components of the Plan are subject to these provisions.

Protected Health Information
The Company will have access to protected health information ("**PHI**") only as permitted under this Plan or as otherwise required or permitted by the Privacy Rules. PHI means information that is created or received by the Plan and relates to:

- past, present, and future physical or mental health or condition of an individual;
- provision of health care to an individual; or
- past, present, or future payment for the provision of healthcare to an individual; and
- that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.

Uses and Disclosures of PHI by the Plan
The Plan may disclose PHI to the Company only if the Privacy Rules specifically permit the use or disclosure, or if the individual authorizes the Plan to use or disclose PHI to the Company.

Plan Administrative Functions
Once the Company receives PHI from the Plan, it may use or disclose PHI only for Plan Administration Functions. "**Plan Administration Functions**" are administrative tasks performed by the Company on behalf of the Plan and exclude employment-related functions and functions performed by the Company in connection with any other benefit or benefit plan of the Company. Plan Administration Functions include, but are not limited to:

- Enrollment and disenrollment activities;
- Verification of participation in the Plan;
- Obtaining premium contributions;
- Determining eligibility for benefits;
- Activities to coordinate benefits with other plans and coverages;
- Final adjudication of appeals of claim denials;
- Exercise of the Plan's rights of reimbursement and subrogation;
- Assisting participants in eligibility, benefit claims matters, inquiries, and appeals;
- Obtaining premium bids;
- Evaluation of health plan design;
- Activities relating to placement, renewal, or replacement of a contract of health insurance or health benefits (including stop-loss and excess loss insurance);
- Legal services and auditing functions (including fraud and abuse detection);
- Business planning, management and general administration;
- Making claims under stop-loss or excess loss insurance;
- Activities in connection with the transfer, merger or consolidation of the Plan, including due diligence.

Privacy Obligations of the Company
With respect to PHI created by or received from the Plan, the Company will:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such PHI;

- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company unless authorized by the individual;

- Report to the Plan any use or disclosure of PHI that is inconsistent with the Privacy Rules of which the Company becomes aware;

- Make PHI available to an individual in accordance with the access requirements of the Privacy Rules;

- Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Rules;

- Make available the information required to provide an accounting of disclosures;

- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services Secretary for purposes of determining compliance with the Privacy Rules;

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

- Ensure that adequate separation between the Plan and the Company is maintained as required by the Privacy Rules. For purposes of maintaining adequate separation between the Plan and the Company, only the Associates or classes of Associates identified in the Company's privacy policies and procedures ("**Authorized Employees**") will be given access to PHI. The section of the Company's privacy policies and procedures that lists these Associates is incorporated by reference into this Plan. The access to and use of PHI by Authorized Employees is restricted to the Plan Administration Functions that the Company performs for the Plan. If an Authorized Employee uses or discloses PHI in ways other than those permitted by the Plan or the Privacy Rules, the Authorized Employee will be subject to the disciplinary procedures described in the Company's Associate handbook. The Company may impose, at its discretion, reasonable sanctions as necessary to ensure that no further non-compliance with the Plan or the Privacy Rules occurs.

Electronic Data Security Obligations of the Company
To the extent the Company maintains electronic PHI, the Company will:

- Reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Company on behalf of the Plan as required by the HIPAA Security Rules;

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Company creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that the required separation between the Plan and the Company is supported by reasonable and appropriate security measures;

- Ensure that any agents, including subcontractors, to whom it provides electronic PHI agree to implement reasonable and appropriate security measures to protect the electronic PHI; and

- Report to the Plan any security incident involving PHI of which it becomes aware.

Qualified Medical Child Support Orders

The Plan Administrator will honor an order that is a "**Qualified Medical Child Support Order**" within the meaning of ERISA Section 609(a)(2)(A) ("**QMCSO**"). The Plan Administrator has established written procedures for determining whether a medical child support order is a QMCSO and for administering the provision of benefits under the Plan pursuant to a valid QMCSO. These procedures are available from the Plan Administrator upon written request at no charge. The Plan Administrator has full discretionary authority within the meaning of the U.S. Supreme Court's decision in Firestone Tire & Rubber v. Bruch (1989) to determine whether a medical child support order is "qualified" within the meaning of ERISA Section 609(a)(2)(A), and reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency that issued the order, up to and including the right to seek a hearing before the court or agency. Upon receipt of a Medical Child Support Order or a National Medical Support Notice issued under applicable state or federal law, the Plan Administrator will take the following steps, within 20 business days:

- Reply to the issuing court or agency if the individual is no longer employed or falls into a class of employees who are ineligible for coverage, or if dependent coverage is not provided.

- Determine if the Order or Notice conforms to the requirements of a QMCSO.

- Notify the issuing court or agency, the Participant, and the affected child(ren) if the Order or Notice is determined not to meet the requirements of a QMCSO.

- Notify the issuing court or agency of the coverage options available under the Plan and any waiting period that exists for coverage under the Plan, if applicable.

- Determine if federal withholding limits or prioritization rules permit the withholding from the Participant's income of the amount required to obtain coverage for the child(ren) specified.

- Notify the Participant of any contributions to be withheld from future pay.

- If appropriate, withhold from the Participant's income any required contributions.

- Notify the Claim Administrator, if applicable, about enrollment of the child(ren).

- Notify the issuing court or agency of the date of enrollment and the date coverage under the Plan will begin.

The Participant and each affected child have the right to request in writing, within 60 calendar days after being notified of the Plan Administrator's decision, that the Plan Administrator again review the status of the Order or Notice. The Participant and each affected child may present additional materials to the Plan Administrator for review. The Plan Administrator may request additional information or material from the Participant and/or affected child(ren). The Plan Administrator must provide sufficient information for the Participant and/or affected child(ren) to understand available options and to assist in appropriately completing the Order or Notice.

Medicaid Eligibility And Assignment Of Rights

The Plan will not take into account that an individual is eligible for, or is currently receiving, medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act ("**State Medicaid Plan**") either in enrolling that individual as a Participant or beneficiary or in determining or making any payment of benefits to that individual. The Plan will pay benefits in accordance with any assignment of rights made by or on behalf of that individual as required under a State Medicaid Plan pursuant to Section 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to the individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same items or services, payment under the Plan will be made in accordance with any state law that provides that the State has acquired the rights with respect to the individual to payment for those items and services under this Plan.

Maternity Benefits

Pursuant to federal law, the Plan, or any insurance issuer providing coverage for maternity benefits under the Plan, will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother's or newborn's treating physician, after consultation with the mother, from discharging the mother or her newborn Child earlier than 48 hours (or 96 hours, as the case may be). The Plan will not require a medical provider to obtain authorization from the Plan (or the insurance issuer) for prescribing a length of stay not in excess of the above periods. Nothing in this provision, however, requires that a woman covered under this Plan give birth in a hospital or stay in the hospital a fixed period of time following the birth of her Child.

Post-Mastectomy Benefits

To the extent the Plan (or any insurance issuer) provides benefits for mastectomies, it will also provide coverage for reconstructive surgery of either or both breasts following a mastectomy (including for the purpose of attaining a symmetrical appearance) and for the treatment of physical complications at all stages of the mastectomy and the recovery period, including lymphedemas.

Genetic Information Nondiscrimination Act

The Plan complies with the Genetic Information Nondiscrimination Act of 2008. Participants and Eligible Dependents are not required to undergo genetic testing, nor shall the Plan use genetic information related to any Employee or family member to determine eligibility to participate in the plan or to determine any required employee contribution for any health benefit provided under the plan.

Mental Health Parity and Addiction Equity Act
The Plan will comply with the Mental Health Parity and Addiction Equity Act of 2008 ("**MHPAEA**") to the extent MHPAEA is applicable to the Plan. Nothing in the Plan will be construed to require any Benefit Program to provide coverage for mental health and/or substance abuse disorder benefits. This section will not create any rights in excess of the minimum required by law.

Right to Choose a Primary Care Provider
The Plan generally allows Participants to designate a primary care provider. Participants have the right to designate any primary care provider who participates in the Plan's network and who is available to accept new patients. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator listed on Schedule A. For children, Participants may designate a pediatrician as the primary care provider. A female participant does not need prior authorization from the Plan or any other person (including a primary care provider) in order to obtain obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator listed on Schedule A.

PLAN ADMINISTRATION

Plan Administrator
North America Benefits-Health and Welfare is the Plan Administrator and has sole responsibility for the administration of the Plan. The Plan Administrator has full discretionary authority to: interpret the Plan; determine eligibility for and the amount of benefits; determine the status and rights of Participants, beneficiaries and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms (including Enrollment Forms); to exercise all of the power and authority contemplated by the Employee Retirement Income Security Act of 1974, as amended, ("**ERISA**") and the Internal Revenue Code of 1986, as amended (the "**Code**") with respect to the Plan; employ or appoint persons to help or advise in any administrative functions; to appoint investment managers and trustees; and generally do anything needed to operate, manage and administer the Plan. The discretionary authority of the Plan Administrator extends to its factual determinations, as well as its construction of Plan terms and its determination of benefit entitlements. The Plan Administrator has the necessary discretionary authority and control over the Plan to require deferential judicial review pursuant to the U.S. Supreme Court decision in Firestone Tire and Rubber Co. v. Bruch (1980).

The Plan has other fiduciaries, advisors, and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. A person or persons to whom an allocation or delegation is made has the same amount of discretion as the Plan Administrator for matters covered by the allocation or delegation. The Claims Administrators are the fiduciaries with respect to Claims processing and benefit determinations. The insurer is the fiduciary for Claims processing for any insured Benefit Program. Refer to the Benefit Program & On-Site Medical Health Centers Information Chart for additional information relating to the Claims Administrators.

The Plan Administrator retains all fiduciary obligations with respect to the Pre-Tax Payment, Day Care FSA and Health Care FSA Programs, except to the extent delegated in writing.

Each fiduciary is solely responsible for its own improper acts or omissions. No fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary.

Indemnification
The Sponsoring Company will indemnify each Associate to whom it has delegated responsibilities for the operation and administration of the Plan against any and all claims, losses, damages, expenses, and liabilities arising from any action or failure to act, except when it is judicially determined to be due to the gross negligence or willful misconduct of the Associate. The Sponsoring Company may choose, at its own expense, to purchase and keep in effect sufficient liability insurance to cover any claim, loss, damage, expense, or liability arising from any Associate's action or failure to act.

Discretion
Wherever it is provided in the Plan that the Sponsoring Company or Plan Administrator may perform or not perform any act, or permit or consent to any action, non-action, or procedure, or wherever they are given discretionary power or authority, they have exclusive discretion; provided, however, that they may not exercise their discretion so as to violate the Code or knowingly to discriminate either for or against any Associate, Participant, or Covered Dependent or any group of these persons.

OTHER IMPORTANT PROVISIONS

Plan Name
DENSO HEALTH & WELFARE PLAN

Plan Number
526

Sponsoring Company's Employer Identification Number
38-2651421

Plan Year
January 1 to December 31 of each year

Sponsoring Company And Agent For Service Of Legal Process
DENSO International America, Inc.
24777 Denso Drive
PO Box 5047
Southfield, Michigan 48086-5047
(248) 350-7500

Service of legal process also may be made upon the Plan Administrator.

Plan Administrator
North America Benefits-Health and Welfare
DENSO International America, Inc.
24777 Denso Drive
PO Box 5047
Southfield, Michigan 48086-5047
(248) 350-7500

Type Of Plan
The Plan is a cafeteria plan intended to satisfy the requirements of Section 125 of the Code and a welfare benefit plan under ERISA.

Funding
The Company pays the cost of the Benefit Programs, other than any amounts you are required to pay to participate in each Benefit Program ("**Benefit Contributions**") under the terms of the Benefit Programs. You will be informed of the amount of any Benefit Contributions at your Initial Enrollment Period and each Open Enrollment Period.

The benefits provided under the Plan will be paid, to the extent permitted by ERISA and the Code, from the general assets of the Company or through insurance. Nothing in this Plan will be construed to require the Company to maintain any fund for its own contributions or segregate any amount that it is obligated to contribute for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the Company from which any payment under the Plan may be made.

Payment Obligations And Role Of Claims Administrator
For those health care Benefit Programs that are Self-funded, if you are covered by the Plan and either the Plan or the Company does not ultimately pay the medical expenses that are eligible for payment under the Plan for any reason, you and your Covered Dependents may be liable for those expenses.

The Claims Administrators under the Self-funded Benefit Programs merely process Claims and do not ensure that any of your medical expenses will be paid. Complete and proper Claims for benefits made by you will be promptly processed; but if there are delays in processing Claims, you will have no greater rights against the Claims Administrators than are otherwise afforded you by law.

Amendment Or Termination Of The Plan
The Sponsoring Company, acting through its Board of Directors or its delegate, may amend, modify, or terminate the Plan at any time in any manner or with respect to any individual in its sole discretion. Any amendment may be made retroactively effective to the extent not prohibited by the Code or ERISA. If the Plan is terminated or partially terminated for any reason, the benefits to which you became entitled prior to the effective date for the Plan's termination will be covered. Termination of the Plan will not reduce or eliminate your right to reduce your compensation earned before the date of termination. A Participating Company other than the Sponsoring Company cannot amend or terminate the Plan, but can terminate the participation of its employees in the Plan.

For insured benefits, the Sponsoring Company may amend the Plan, including the benefits provided by the Plan, by agreeing with the insurance company to amend or modify the underlying policies or contracts that, with this document, constitute the Plan. The Sponsoring Company may also amend an insured Benefit Program, including the benefits provided, by changing policies or insurance companies.

Nondiscrimination Rules
For each calendar year, the nontaxable benefits under the Plan provided to key employees, as defined in Code Section 416(i), cannot exceed 25% of the aggregate nontaxable benefits provided to all Participants under the Plan. In addition, the Plan cannot discriminate in favor of "highly compensated individuals," as defined in Code Section 105(h)(5), as to eligibility to participate or as to contributions or benefits, or as defined in Code Section 125(e)(2), as to eligibility to participate, or in favor of "highly compensated participants," as defined in Code Section 125(e)(1), as to contributions or benefits.

If the Company determines at any time that the Plan may not satisfy any nondiscrimination rule in the Code, the Company may take whatever action it deems appropriate to assure compliance with the rule. Any action will be taken uniformly with respect to similarly-situated Participants. The action may include, without limitation, the modification of your enrollment elections, and reduction of your elected benefits to the extent necessary to satisfy the nondiscrimination rule, with or without your consent. If your Plan benefits are affected, you will be notified of the action to be taken.

Compliance With Tax Law
The Plan is intended to comply with all applicable law, including Code Section 125. It will be considered amended to the extent necessary to comply with Code Section 125. However, neither the Plan, the Sponsoring Company, the Plan Administrator, nor any Plan fiduciary represents or guarantees that this Plan in fact meets the requirements of any provision of the Code. Any other provision of this Plan notwithstanding, individuals who are not treated as employees for purposes of the tax treatment of any contribution to any Benefit Program are not eligible to participate in the Plan. The Plan cannot be operated so as to defer the receipt of compensation in a manner that violates Code Section 125.

Limitation Of Rights
The Plan does not constitute a contract between you and the Company. Nothing contained in the Plan gives you the right to be retained in the service of the Company or to interfere with the right of the Company to discharge you at any time, with or without cause, regardless of the effect that the discharge will have upon you as a Participant in the Plan.

Overpayments
An "**Overpayment**" occurs if the Plan pays an amount not payable under the Plan, if the Plan pays an expense or benefit more than once, or if an expense or benefit is paid by both the Plan and a third party. An expense or benefit is considered paid if it is paid to you or to someone else (for example, a health care provider) on your or your Covered Dependent's behalf.

If an Overpayment is made by the Plan, the Plan has the right to recover the Overpayment. If that Overpayment is made to a health care provider, the Plan may request a refund of the overpayment from either you or the provider. If the refund is not received from either you or the

provider, the Overpayment will be deducted from future Plan benefits available to you or your Covered Dependents or from your wages. Any Overpayment you owe due to your or your Covered Dependent's ineligibility for Plan benefits will be offset by the amount of any Benefit Contributions you paid for coverage for the person while ineligible.

Insurance Rebates
If the Company or Plan receives an Insurance Rebate or other distribution from an Insurance Company in connection with medical loss ratio standards as set forth in Section 2718 of the Public Health Service Act, the portion of such rebate or distribution attributable to participant contributions shall be utilized, at the sole discretion of the Plan Administrator, for any permissible plan purpose. Such purposes shall include, but not be limited to, the payment of future participant premium payments, benefit enhancements, or any other use permitted by law.

Designation of Entity for Payment of Fees
The Plan Administrator is hereby designated on behalf of the Plan and its Participating Companies to make the necessary filings and to pay the fees required by Code Section 4376 to fund the Patient-Centered Outcomes Research Institute. At its discretion, the Plan Administrator may permit a Participating Company to make such filings and payments separately, unless prohibited by law.

Forfeitures
Failure to claim any amount or cash any check that becomes payable to you or is paid on your behalf under this Plan within two years after such amount first becomes payable, will result in such amount being forfeited. Such amounts shall cease to be a liability of the Plan, provided due and proper care has been exercised by the Plan Administrator in attempting to make such payment.

Entire Representation
This document, along with any summary, schedule of benefits, or Booklet describing any Benefit Program, together are the entire description of the benefits provided under the Plan. They supersede any previous or contemporary document, representation, negotiation, or agreement (whether written or oral).

Acceptance; Cooperation
If you accept benefits under this Plan, you are considered to have accepted its terms, and agree to perform any act and to execute any documents that may be necessary or desirable to carry out this Plan or any of its provisions.

Governing Law
The Plan is to be construed and enforced in accordance with the laws of the State of Michigan, to the extent not preempted by federal law.

Construction
Words used in the masculine apply to the feminine where applicable. Wherever the context of the Plan dictates, the plural should be read as the singular, and the singular as the plural.

Non-Assignability Of Rights
No interest under the Plan is subject to assignment or alienation, whether voluntary or involuntary. Any attempt to assign or alienate any interest will be void.

Errors
An error cannot give a benefit to you if you are not actually entitled to the benefit.

Severability
The enforceability of any provision of the Plan will not affect the enforceability of the remaining provisions of the Plan.

STATEMENT OF ERISA RIGHTS

Under the Medical, Dental, Vision, EAP, Health Care FSA, STD, LTD, Life/AD&D, Voluntary Benefits, Business Travel Accident Insurance, On-Site Medical, and Healthy Horizons Programs, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants will be entitled to:

Receive Information About Your Plan And Benefits

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

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

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary financial report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, Spouse, or Covered 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 this coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions By Plan Fiduciaries
In addition to creating rights for Plan Participants, ERISA imposes duties upon the persons who are responsible for the operation of this 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 the other Plan Participants and beneficiaries.

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

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

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

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

INDEX OF DEFINED TERMS

EXECUTION

IN WITNESS WHEREOF, DENSO International America, Inc. has caused this amendment and restatement of the Plan, captioned "DENSO HEALTH & WELFARE PLAN," to be executed by its duly authorized officer this ____ day of _____, 2020, to be effective January 1, 2020.

DENSO INTERNATIONAL AMERICA, INC.

By: _____

Its: _____

PARTICIPATING COMPANIES CHART

Participating Company	Employer Identification Number
DENSO Manufacturing Arkansas, Inc. (DMAR) 100 Denso Road Osceola, AR 72370	20-0068644
DENSO Manufacturing Athens Tennessee, Inc. (DMAT) 2400 Denso Drive Athens, TN 37303	55-0809275
DENSO Manufacturing Michigan, Inc. (DMMI) One Denso Road Battle Creek, MI 49037	38-2555024
DENSO Manufacturing Tennessee, Inc. (DMTN) 1720 Robert C. Jackson Drive Maryville, TN 37801	62-1364854
DENSO Products and Services Americas, Inc. (DPAM) 3900 Via Oro Avenue Long Beach, CA 90810	95-2677846
DENSO Manufacturing North Carolina, Inc. (DMNC) 470 Crawford Road Statesville NC 28625	62-1348671

BENEFIT PROGRAM & ON-SITE MEDICAL HEALTH CENTERS INFORMATION CHART

January 1, 2020

Contact information regarding the Insurance Company or Claims Administrator for each of the Benefit Programs is listed below for your convenience and ease of reference. However, if you need assistance at any time with an appeal, you may contact the DENSO Benefits Helpline toll-free at: (855) 311-2115 or e-mail DENSO@benefitadvocates.net.

Benefit Program	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
Medical Program (includes Telemedicine Program) • **Express Way** • **MainStreet** • **OpenRoad**	**Self-funded** Filing a Claim (Emergency Care Claim, Pre-Service Concurrent Care Claims, and Post-Service Claim): Appeal of Denied Claim:	**Blue Cross Blue Shield of Michigan** 888-605-2563 Blue Cross Blue Shield of Michigan DOL/ERISA Appeals 600 E. Lafayette Blvd., Mail Code 2004 Detroit, MI 48226-2998 (800) 810-BLUE www.bcbsm.com
Prescription Drugs (Part of the Medical Program)	**Self-funded** Filing a Claim: Appeal of Denied Claim:	**OptumRx** 800-41DENSO OptumRx Appeals and Grievances 3515 Harbor Rd. Costa Mesa, CA 92626 Mail Stop CA 106-0286 Or Fax to: (877) 239-4565 Attn: OptumRx Appeals and Grievances

Benefit Program	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
Behavioral Health and Substance Abuse Claims (Part of the Medical Program)	**Self-funded** Filing a Claim: Appeal of Denied Claim:	**Behavioral Health Systems** (800) 245-1150 Behavioral Health Systems BHS Clinical Division Two Metroplex Dr., Ste. 500 Birmingham, AL 35209 Or Fax to: (205) 879-1178 To expedite an appeal, call (800) 245-1150
Dental Program	**Self-funded** Filing a Claim (only Post-Service Claims for the Dental Program): First and Second Level Appeal of Denied Claim:	**Delta Dental of Tennessee** (800) 223-3104 Delta Dental of Tennessee Attn: Professional Relations Advisory Committee 240 Venture Cir. Nashville, TN 37228-1699 (800) 223-3104 www.deltadentaltn.com Or Fax to: (615) 244-8108 Attn: Professional Advisory Committee
Vision Program	**Insured** Filing a Claim (only Post-Service Claims for the Vision Program): Appeal of Denied Claims:	**Superior Vision Services** (800) 507-3800 Superior Vision Services P.O. Box 967 Rancho Cordova, CA 95741

Benefit Program	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
STD Program	**Self-funded** Filing a Claim and First and Second Level of Appeal of Denied Claim:	**Matrix Absence Management, Inc.** Matrix Absence Management Quality Assurance Review c/o RSLI PO Box 13498 Philadelphia, PA 19101
LTD Program	**Insured** Filing a Claim: Appeal of Denied Claim:	**Reliance Standard Life Insurance Company** Matrix Absence Management, Inc. Seven Skyline Drive Suite 275 Hawthorne NY 10532 (800) 866-2301 Reliance Standard Life Insurance Company Quality Review Unit PO Box 8330 Philadelphia, PA 19101-8330
Life/AD&D Program	**Insured** Filing a Claim and Appeal of a Denied Claim:	**Reliance Standard Life Insurance Company** (800) 644-1103 Reliance Standard Life Insurance Company Quality Review Unit PO Box 8330 Philadelphia, PA 19101-8330

Employee Assistance Program	**Self-funded** Filing a Claim Appeal of Denied Claim:	**Behavioral Health Systems** (800) 245-1150 BHS Clinical Division Two Metroplex Dr., Ste. 500 Birmingham, AL 35209 Or Fax to: (205) 879-1178 To expedite an appeal, call (800) 245-1150
Pre-Tax Payment Program	**Self-funded** Claims and Appeal of Denied Claim:	**Self-administered by the Company** North America Benefits-Health and Welfare DENSO International America, Inc. 24777 Denso Drive PO Box 5047 Southfield, MI 48086-5047 (248) 350-7500
Day Care FSA Program	**Self-funded** Claims and Appeal of Denied Claims:	**Discovery Benefits** Discovery Benefits (866) 451-3399 www.discoverybenefits.com
Health Care FSA Program	**Self-funded** Claims and Appeal of Denied Claims:	**Discovery Benefits** Discovery Benefits (866) 451-3399 www.discoverybenefits.com
Health Savings Account Contributions Program	**Self-funded** Claims and Appeal of Denied Claims:	**OptumBank** OptumBank (866) 234-8913 www.optumbank.com

Business Travel Accident Insurance Program	**Insured** Filing a Claim: Appeal of Denied Claim:	**ACE American Insurance Co.** (800) 352-4462 (800) 352-4462
DENSO Family Health Center – DMAT (Part of the On-Site Medical Program)	**Self-Funded** Claims and Appeal of Denied Claims:	**Tennova Healthcare** 2400 Denso Drive Athens, TN 37303 (423) 746-1043 North America Benefits-Health and Welfare DENSO International America, Inc. 24777 Denso Drive PO Box 5047 Southfield, MI 48086-5047 (248) 350-7500
DENSO Family Health Center – DMTN (Part of the On-Site Medical Program)	**Self-Funded** Claims and Appeal of Denied Claims:	**Premise Health** DENSO Family Health Center 1720 Robert C. Jackson Dr. Maryville, TN 37801 Processed by Medical Program and Prescription Drug claims administrators—see information above.
DENSO Family Health Center - DMMI (Part of the On-Site Medical Program)	**Self-Funded** Claims and Appeal of Denied Claims:	**Premise Health** 4909 Wayne Rd. Battle Creek, MI 49037 Processed by Medical Program and Prescription Drug claims administrators—see information above.

Voluntary Benefits • **Critical Illness** • **Accident** • **Hospital Indemnity**	**Insured** <u>Claims and Appeal of Denied Claims</u>: <u>Claims</u>: <u>Appeal of Denied Claims</u>: Claims:	**American Heritage Life Insurance Company and Reliance Standard Life Insurance Company** **American Heritage Life Insurance Company** 1776 American Heritage Life Drive Jacksonville, FL 32224 (904) 992-1776 **American Heritage Life Insurance Company** 1776 American Heritage Life Drive Jacksonville, FL 32224 (904) 992-1776 **American Heritage Life Insurance Company** 1776 American Heritage Life Drive Customer Service Dept. Jacksonville, FL 32224 (800) 348-4489 **Reliance Standard Life Insurance Company** PO Box 8330 Philadelphia, PA 19101-8330 (866) 375-0775
Healthy Horizons Program	**Self-Funded** <u>Claims and Appeal of Denied Claims</u>:	**HealthbyDesign** HealthbyDesign (866) 996-2155 www.densohealthyhorizons.com (requires registration)
COBRA Administration	**Self-Funded** <u>Claims and Appeal of Denied Claims</u>:	**Discovery Benefits** Discovery Benefits (866) 451-3399 www.discoverybenefits.com

Eligibility Claims	<u>Claims and Appeal of Denied Claims</u>:	**Self-Administered by the Company** North America Benefits-Health and Welfare DENSO International America, Inc. 24777 Denso Drive PO Box 5047 Southfield, MI 48086-5047 (248) 350-7500

DENSO

Crafting the Core