



Administrative Information

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Administrative Information

This section contains information on the administration and funding of all the plans described in this book, as well as your rights as a plan participant under the Employee Retirement Income Security Act of 1974 (ERISA). It is important for you to understand your rights, the procedures you need to follow, and the appropriate contacts you may need in certain situations.

This section is to be read along with each of the sections of this book which summarize the key provisions of the Company's benefit plans. Keep in mind that any discussion in this section of rights or protections under ERISA applies only to the ERISA plans unless indicated otherwise.

Nothing in this document shall be construed as an employment contract or employment agreement. The Company may unilaterally change the provisions contained herein anytime at its own discretion.

Plan Sponsor

Consolidated Nuclear Security, LLC is the sponsor of the employee benefit plans described in this book. You can reach the plan sponsor as follows:

Consolidated Nuclear Security, LLC
PO Box 2115
602 Scarboro Road
Oak Ridge, TN 37831-2115
(865) 574-1500
(877) 861-2255

Plan Administrator / Claims Administrator

Consolidated Nuclear Security, LLC has delegated authority to the Benefits and Investment Committee to serve as the Plan Administrator of the employee benefit plans described in this book. You can reach the Plan Administrator as follows:

Benefits and Investment Committee
Consolidated Nuclear Security, LLC
PO Box 2115
602 Scarboro Road
Oak Ridge, TN 37831-2115
(865) 574-1500
(877) 861-2255

In carrying out its responsibilities under the plans, the Benefits and Investment Committee, as the Plan Administrator, has the exclusive responsibility and full discretionary authority to control the operation and administration of the plans, including but not limited to, the power to interpret the terms of the plans, to determine eligibility for entitlement to plan benefits, and to resolve all interpretive, equitable, and other questions that arise in the operation and administration of the plans. All actions or determinations of the Plan Administrator are final, conclusive, and binding on all persons.

The Plan Administrator may delegate some or all of these duties to other persons or entities. For example, the Plan Administrator has retained one or more third party administrators to provide certain administrative services with respect to one or more of the welfare plans, including making determinations as the "claims administrator" regarding participant claims for benefits. The contact information for the claims administrators is located later in this section of this book. In addition, with respect to the retirement plans, the authority to make initial claims determinations has been delegated to an employee of the Company. The appeals of such determinations are decided by the Benefits

Appeals Committee. The Benefit Appeals Committee may be contacted as follows:

Benefit Appeals Committee
Consolidated Nuclear Security, LLC
PO Box 2115
602 Scarboro Road
Oak Ridge, TN 37831-2115
(865) 574-1500
(877) 861-2255

A person or entity to whom these duties have been delegated acts with the discretionary authority granted to the Plan Administrator.

The term “Company” means Consolidated Nuclear Security, LLC.

The term “Benefit Plans Office” refers to the Company’s benefits department located in Oak Ridge, Tennessee.

Employer Identification Number

The employer identification number assigned by the Internal Revenue Service to the Company is 45-4482782.

Plan Documents

This book summarizes the key features of each of the employee benefit plans sponsored by the Company and serves as the summary plan description for each of the plans for purposes of ERISA. It applies to eligible employees of the Company, including those represented by collective bargaining agreements to the extent that they have been negotiated and accepted by the duly certified representatives of participating units. Complete details of each of the plans can be found in the official plan documents, insurance contracts, and trust agreements (as applicable) that legally govern the operation of the plans. Summaries of the plans are included in the tabs of this book. **All statements made in this book are subject to the provisions and terms of the plan documents.**

Copies of those documents, as well as the latest annual reports of plan operations and plan descriptions as filed with the Internal Revenue Service or Department of Labor are available for your review any time during normal working hours in the office of the Plan Administrator. Upon written request to the Plan Administrator, at the address previously mentioned, copies of any of these documents will be furnished to a plan participant or beneficiary at a nominal charge. In addition, once each year you will receive a copy of the summary annual reports of the plans’ financial activities (if applicable), which will be made available to you at no charge. In the event of a conflict between the official plan documents and the summaries in this book, the plan documents are controlling.

Depending on where you live, there may be state law requirements or mandated coverages for health and welfare plans. If the Company-sponsored plans have to comply with those requirements or mandated coverages, your benefits may vary from the benefits described in this book. Requirements under the law and the terms of benefits are set forth in the insurance company’s certificate of coverage for the insured coverage. In the event of any conflict between the summaries in this book and such certificate of coverage the provisions of such certificate of coverage shall control. You may request a copy of such certificate of coverage by following the steps outlined in the “Administrative Information” section” of this book.

Claiming Benefits

You or your Beneficiary must file the appropriate forms to receive any benefits, or to take any other action under any of the plans, as described throughout this book. The procedure for claiming benefits and appealing the denial may differ for different types of plans and different types of benefits under each plan. The following section describes claims and appeals procedures based on the type of claim and the type of plan. All forms required to take any action under the plans are available through the Benefit Plans Office or, in some cases, the claims administrator. All completed forms must be submitted to the appropriate office, as described throughout this book, within any time period required by the administrator.

You have the right to file a formal claim for benefits, ask whether you have a right to any benefits or appeal the denial of a claim for benefits under each of the plans. Your authorized representative may do this on your behalf. References to the term “you” in this section, include the participant or beneficiary making a claim, inquiry or appeal and the authorized representative of such person.

With respect to the welfare plans, the Plan Administrator has delegated to the claims administrator (or delegates) the discretion to interpret plan provisions, construe unclear terms, and otherwise make all decisions and determinations, including factual determinations and whether welfare plan benefits are owed and in what amount. The Plan Administrator retains responsibility for determining whether an individual is eligible to participate in a welfare plan.

Where a claims administrator has been appointed, the claims administrator is listed in a chart located later in this section under the heading “Other Administrative Facts.” The Benefits and Investment Committee (or its delegate) acts as the claims administrator with respect to eligibility and enrollment determinations for all of the plans and any matter not delegated to a third party service provider or to the Benefits Appeals Committee. In addition, the Benefits Appeal Committee has been appointed to handle all appeals related to retirement plan claims and all appeals with respect to eligibility and enrollment determinations for all of the welfare plans. If you have a question about who acts as the claims administrator with respect to a particular benefit or plan, you should contact the Plan Administrator.

To make a formal claim for benefits, you must file a written claim with the Plan Administrator or, where applicable, the claims administrator. The way in which you file a claim for benefits and appeal any claim that is denied (or any other adverse benefit determination) will differ depending on the type of benefit that is offered under the plan. An adverse benefit determination includes any denial, reduction or termination of a benefit, a failure to make a payment, or, in the case of the Company’s medical plans and effective April 2, 2018, disability plans, a rescission of coverage. There are three types of claims procedures contained herein:

- The Health Claims Procedures, which are special procedures that apply to claims related to the Company’s health plans.
- The Disability Claims Procedures, which are special procedures that apply to claims related to the Company’s disability plans or any other benefit based on the claims administrator’s determination of disability.
- The General Claim Procedures, which apply to claims related to all of the Company’s other ERISA-covered plans.

Exhaustion of Administrative Remedies and Limitations on Actions

You must use and fully exhaust all of your actual or potential rights under each plan's administrative claims and appeals procedures by filing an initial claim and then seeking a timely appeal of any denial (or other adverse benefit determination) before you file a lawsuit. This relates to claims for benefits, eligibility and to any other issue, matter or dispute (including any plan interpretation or amendment issue).

Failure to follow the administrative claims and appeals procedures in a timely manner will cause you to lose your right to sue regarding an adverse benefit determination or any other matter covered by this provision.

Discretionary Authority

Depending upon the circumstances, the Plan Administrator, the Benefits Appeals Committee, or the claims administrator (with respect to any matters delegated to the claims administrator) have the discretionary authority to construe and to interpret the plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and their decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect. Benefits under the plan will be paid only if the Plan Administrator, the Benefits Appeals Committee or the claims administrator, as applicable, decides in its discretion that a participant is entitled to them.

Health Claims Procedures

You may file claims for health plan benefits, either yourself or via an authorized representative appointed by you or the court. Either you or your authorized representative may appeal an adverse claim decision. Benefit programs covered by the Health Claims Procedures include the medical plan, dental plan, vision plan, employee assistance program, and health care flexible spending account.

Initial Health Claims

If you file a claim for health benefits, you will receive a notice from the claims administrator regarding the claim according to the procedures described below. The procedure by which your claim will be decided varies depending on the type of claim that is filed.

Urgent Health Care Claims

If you file an Urgent Care Claim, you will receive notice of the benefit determination as soon as possible, but not later than 72 hours after the claim is received unless you fail to provide sufficient information for the plan to make a decision. Notice of the benefit determination may be oral, with a written or electronic confirmation to follow within 3 days.

An Urgent Care Claim is a claim filed by a claimant relating to medical care provided under the plan if (1) the plan requires the claimant to notify the plan or receive approval prior to receiving the medical care, and (2) a delay in treatment could seriously jeopardize the person's life or health or the ability to regain maximum function, or in the opinion of a physician with knowledge of the person's medical condition, could cause severe pain that cannot be adequately managed without the care or treatment that is the subject to the claim. The determination of whether a claim is an Urgent Care Claim will be made by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine or by a physician with knowledge of your medical condition.

If there is not sufficient information to decide the claim, you will be notified of the specific information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information. You will be notified of the decision as soon as possible, but not more than 48 hours after the end of that additional time period (or after receipt of the specified information, if earlier).

Other Health Claims (Pre-Service and Post-Service)

If the plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim (provided it is not an Urgent Care Claim). You will be notified of the decision as soon as possible, but not later than 15 days after receipt of the pre-service claim.

For other health claims (post-service claims), you will be notified of the decision as soon as possible, but not later than 30 days after receipt of the claim.

For a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the plan's control. In that case, you will be notified of the extension before the end of the initial 15-day or 30-day period.

For example, these periods may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the plan's decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a plan representative responsible for handling benefit matters, but which otherwise fail to follow the plan's procedures for filing pre-service claims, you will be notified of the failure within five days (within 24 hours in the case of an Urgent Care Claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Health Treatment

If you are receiving an ongoing course of treatment which was previously approved for a specific period of time or number of treatments, you will be notified in advance if the plan intends to terminate or reduce benefits for the course of treatment so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves urgent care, you must request an extension of the course of treatment at least 24 hours before its expiration. You will be notified of the decision within 24 hours after receipt of the request.

Notification of Initial Health Claim Decision

For claims and other adverse benefit determinations that relate to the medical plan, the claims administrator will provide you with a written or electronic notification of any adverse benefit determination, including any claim for plan benefits which is denied in whole or in part, that will include:

- Information that enables you to identify the claim involved (including, if applicable, the date of service, the health care provider and the claim amount), and a statement describing the availability, upon request, of the diagnosis and treatment codes (and their meanings)
- The specific reasons for the adverse benefit determination, including the denial code (and its meaning), and a description of any standard that was used in denying the claim

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- References to the specific plan provisions on which the benefit determination is based, including plan limitations or exclusions
 - A description of any additional information needed to complete the claim and an explanation of why such information is necessary
 - A description of the plan's internal claim review procedures and applicable time limits
 - A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review
 - A description of available external review processes, including information regarding how to initiate any appeal
 - The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

For all other claims and adverse benefit determinations relating to any other health plan, including the dental plan, vision plan, employee assistance program and health care flexible spending account, the claims administrator will provide you with a written or electronic notification of any adverse benefit determination, including any claim for plan benefits which is denied in whole or in part, that will include:

- The specific reasons for the adverse benefit determination with reference to the specific plan provisions on which the benefit determination is based
- A description of any additional information needed to complete the claim and an explanation of why such information is necessary
- A description of the plan's claim review procedures and applicable time limits
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

In all cases, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either a copy of or statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination will be provided to you free of charge upon request.

In addition, if the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit when applying the terms of the plan to the participant's medical circumstances, an explanation of the scientific or clinical judgment for the denial will be provided, or the denial will state that such an explanation is available upon request at no cost to you.

Appeal of a Health Claim

If your claim is denied or you receive some other type of adverse benefit determination, you may request that it be reviewed. You will have 180 days following receipt of an adverse benefit decision to appeal the decision. If you fail to appeal within this period of time, you may not later seek a reconsideration of your claim, and the initial determination will be final.

To file an appeal, you must submit it in writing to the claims administrator, except for Urgent Care Claims. If you appeal, you will be notified of the decision not later than 72 hours (Urgent Care Claim), 30 days (for pre-service claims) or 60 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or information were submitted in connection with the initial claim. You may also request that the plan provide you, free of charge, copies of all documents, records and other information "relevant" to the claim (as that term is defined in ERISA).

The appeal will take into account all documents, records and other information that you submit or that are submitted on your behalf regarding the claim, without regard to whether the information was considered in the initial benefit determination. The appeal will not give deference to the initial decision regarding the claim and will be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the initial denial, nor the subordinate of such individual.

An expedited appeal for Urgent Care Claims may be initiated by a telephone call to the claims administrator. If you appeal an Urgent Care Claim, all necessary information, including the appeal decision, will be communicated to you by telephone, facsimile, or other similar method. The contact information for the claims administrator is located at the end of this Administrative Information section. If you have questions about how to submit an appeal, you should contact the Plan Administrator.

In reconsidering any denial that is based in whole or in part on a medical judgment, (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate) the claims administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is not the individual that was consulted in connection with the initial denial of the claim nor a subordinate of any such individual. If the plan obtains other medical or vocational experts in connection with your claim, they will be identified upon your request, regardless of whether the plan relies on their advice in making any benefit determinations.

For purposes of medical claims, you may review your claim file and present evidence and testimony in support of your claim. In addition, before your appeal is decided, you will be given, free of charge, any new or additional evidence considered, relied upon, or generated by the claims administrator in connection with your claim. This evidence will be given to you as soon as possible and sufficiently in advance of the date on which the appeal decision is required to be provided to give you a reasonable opportunity to respond before that date.

Notification of Health Claim Appeal

For appeals that relate to the medical plan, if your appeal is denied in whole or in part, the claims administrator will provide you with a written or electronic notification that will include:

- Information that enables you to identify the claim involved (including, if applicable, the date of service, the health care provider and the claim amount), and a statement describing the availability, upon request, of the diagnosis and treatment codes (and their meanings).
- The specific reason(s) for the adverse benefit determination, including the denial code (and its meaning), and a description of any standard that was used in denying the claim.
- References to the specific plan provisions on which the benefit determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.
- A description of available external review processes, including information regarding how to initiate any appeal.
- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

For appeals that relate to any other health plan, including the dental plan, vision plan, employee assistance program, and health care flexible spending account, if your appeal is denied in whole or in part, the claims administrator will provide you with a written or electronic notification that will include:

- The reasons for the decision, again with reference to the specific plan provisions on which that decision is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of pertinent documents, records, and other information relevant to your claim for benefits; and
- A statement describing any voluntary appeal procedures offered by the plan and your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

In all cases, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either a copy of or statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the determination will be provided free of charge to you upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to your medical circumstances, or a statement that such an explanation is available will be provided to you free of charge upon request.

The plan's claims review procedures do not generally include any voluntary levels of appeal (such as voluntary arbitration). Although, you may request an external review of certain types of medical plan claims. This external review process is completely voluntary.

Your Right to an External Review

Federal law gives you the right, in certain circumstances, to have an adverse benefit determination reviewed by an external independent review organization after you exhaust your rights under the internal claims and appeals procedure. The following is a general description of the external review process. However, you should review your notice of adverse benefit determination carefully. The notice may contain updated information in the event the external appeals process changes.

Types of Eligible Determinations

The external review process under the medical plan gives you the opportunity for review of a final internal adverse benefit determination, and in limited cases, an adverse benefit determination conducted pursuant to applicable law. Your request will be eligible for external review only if it qualifies as one of the following:

- **Medical Judgment Claims and Appeals:** External review procedures apply to adverse benefit determinations that involve medical judgments (including those based on medical necessity, appropriateness, health care setting, and level of care, effectiveness of a benefit or experimental or investigational determinations).
- **Rescissions of Coverage:** External review procedures apply to rescissions of coverage and whether a rescission has any effect on a particular benefit at the time of a rescission.

External review procedures do not apply to any other adverse determination, including eligibility appeals.

External Review Request

You must submit the request for external review form to the claims administrator within 123 calendar days of the date you received the notice regarding your final internal adverse benefit determination (or adverse benefit determination, if applicable). If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file for a voluntary external review, any applicable statute of limitations will be tolled while the external review is pending. The filing of a claim will have no effect on your rights to any other benefits under the plan. However external review is voluntary and you are not required to undertake it before pursuing legal action. If you choose not to file for external review, the plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Within five business days following the date the external review request is received, the claims administrator will complete a preliminary review to determine whether you meet the requirements for an external review. To be eligible, you must meet the following requirements:

- You are or were covered under the medical plan at the time the item or service was requested or, in the case of a retrospective review, were covered under the medical plan at the time the health care item or service was provided;
- The denied appeal does not relate to your failure to meet the requirements for eligibility under the terms of the medical plan;
- You have exhausted the internal appeal process; and
- You have provided all the information and forms required to process an external review.

If the claims administrator does not adhere to the federal requirements for handling internal claims and appeals, you are deemed to have exhausted the internal claims and appeal process unless such failure was (1) De Minimis; (2) non-prejudicial; (3) attributable to good cause or matters beyond the medical plan's control; (4) in the context of an ongoing good faith exchange of information; and (5) not reflective of a pattern or practice of non-compliance. Upon written request, you are entitled to an explanation of the medical plan's basis for asserting that it meets this standard.

Within one business day after completing the preliminary review, the claims administrator will send you a written notice regarding your request. If the request is complete but not eligible for external review, the notice will include the reasons for its ineligibility and contact information. If the request is not complete, the notice will describe the information or materials needed to make the request complete and you will have the later of the remaining time within the four month filing period or 48 hours following receipt of the notification to perfect your external review request.

Procedures After your External Review Request is Approved

If your external review request is eligible, the claims administrator will assign it to an Independent Review Organization (IRO) as required under federal law to conduct the external review. The assigned IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the assigned IRO within 10 business days following the date the notice is received additional information that the IRO must consider when conducting the external review. Any additional information received by the IRO from you will be shared with the claims administrator and the plan. Upon receipt of this information by the claims administrator and the plan, the claims administrator may reconsider its prior appeal decision and may reverse the prior denial of the internal appeal. If the claims administrator reverses its decision and fully approves the internal appeal, then your claim will be paid accordingly and the external review will be terminated.

If the external review is not terminated as noted above, the IRO will review all information and documents related to your denied internal appeal. The IRO is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision to the extent required under applicable law:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the plan, you, or your treating provider;
- The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the claims administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claimant, plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

The IRO will deliver a notice of the final external review decision to you and the claims administrator. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination, the plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review Requests

You may also make an expedited external review request to the claims administrator at the time you receive (1) a denied urgent care internal claim if you have also filed at the same time an internal appeal; (2) a denied urgent care internal appeal; or (3) a denied internal appeal, which concerns an admission, availability of care, conducted stay or medical care item or service for which you have received emergency services and have not been discharged from the facility. Upon receipt of such a request, the claims administrator will determine whether you are eligible for an expedited external review. If you are eligible, the claims administrator will notify you immediately. The IRO will follow the procedures discussed above with respect to standard external reviews, provided that certain procedures will be provided on an expedited basis as follows:

- The claims administrator must provide all documentation with respect to the denied internal claim or appeal immediately to the IRO; and
- Upon a determination that a request is eligible for external review following preliminary review, the claims administrator will assign an IRO. The IRO will provide notice of the external review decision, as expeditiously as the circumstances require, but in no event more than 72 hours

after the IRO receives the request for the expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you, the claims administrator and the plan.

Foreign Language Assistance (Medical Plan only)

If you reside in a county where 10% or more of the population is literate in a non-English language (as determined in accordance with data provided by the United States Census Bureau and the United States Department of Labor), the health plan must provide the following language assistance:

- Oral language services in the applicable non-English language for claims, appeals, and external review;
- Upon request, an explanation of benefits (EOB) or other adverse benefit determination in the applicable non-English language; and
- Provide in English versions of EOBs and other adverse benefit determinations a statement in any applicable non-English language indicating how to access the language services.

If you have any questions regarding this foreign language assistance, please see the statements on your EOBs or otherwise contact the claims administrator or the Benefit Plans Office.

Disability Claims Procedures

You may file claims for disability plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative you or a court appoints. Benefit programs covered by the disability claim procedures include the Long-Term Disability plan. These procedures may apply to other Benefit Programs if the claims administrator of that program must determine that you (or your dependent) is disabled in order to receive a benefit under that program.

Initial Disability Claims

If you file a claim for disability benefits, you will receive a notice from the claims administrator regarding the claim according to the procedures described below.

If you file a claim for disability benefits, you will be notified of the plan's benefit determination not later than 45 days after the plan's receipt of the claim. The time period may be extended up to an additional 30 days due to circumstances outside the plan's control. In that case, you will be notified of the extension before the end of the initial 45-day period. If a decision cannot be made within this 30-day extension period due to circumstances outside the plan's control, the time period may be extended up to an additional 30-day extension period, in which case you will be notified of the additional extension before the end of the initial 30 day extension. The notice of extension will explain the standards on which entitlement to a benefit are based, the unresolved issues that prevent a decision, and the additional information needed to resolve those issues. You will be given at least 45 days after receiving the notice to furnish that information.

Notification of Initial Disability Claim Decision

The claims administrator will provide you with a written or electronic notification of any adverse benefit determination, including any claim for plan benefits which is denied in whole or in part, that will include:

- The specific reasons for the denial with reference to the specific plan provisions on which the denial was based
- A description of any additional information needed to complete the claim and an explanation of why such information is necessary
- A description of the plan's claim review procedures and applicable time limits
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

In all cases, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either a copy of or statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination will be provided to you free of charge upon request, or for claims filed after April 1, 2018, a statement that such rule, guideline, protocol or other similar criteria does not exist.

If the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit when applying the terms of the plan to the participant's medical circumstances, an explanation of the scientific or clinical judgment for the denial will be provided, or the denial will state that such an explanation is available upon request at no cost to you.

For claims filed after April 1, 2018, the notice will include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (as applicable) (1) the views that you present of the health care professionals treating you and of the vocational professionals who evaluated you; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination; and/or (3) a determination made by the Social Security Administration that you are disabled.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim of benefits.

Appeal of a Disability Claim

If your claim is denied or you receive some other type of adverse benefit determination, you may request that it be reviewed. You will have 180 days following receipt of an adverse benefit decision to appeal the decision. If you fail to appeal within this period of time, you may not later seek a reconsideration of your claim, and the initial claim determination or other adverse benefit determination will be final.

To file an appeal, you must submit it in writing to the claims administrator. The contact information for the claims administrator is located at the end of this Administrative Information section.

You will be notified of the decision not later than 45 days after the appeal is received. If special circumstances require an extension of time of up to an additional 45 days, you will be notified of such extension during the 45 days following receipt of your request. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected.

You may submit written comments, documents, records and other information relating to your claim,

whether or not the comments, documents, records or information were submitted in connection with the initial claim. You may also request that the plan provide you, free of charge, copies of all documents, records and other information “relevant” to the claim (as that term is defined in ERISA). The appeal will take into account all documents, records and other information that you submit or that are submitted on your behalf regarding the claim, without regard to whether the information was considered in the initial benefit determination. The appeal will not give deference to the initial decision to deny the claim and will be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the initial denial, nor the subordinate of such individual.

In reconsidering any denial that is based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate), the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is not the individual that was consulted in connection with the initial denial of the claim nor a subordinate of any such individual. If the plan obtains other medical or vocational experts in connection with your claim, they will be identified upon your request, regardless of whether the plan relies on their advice in making any benefit determinations.

For claims filed after April 1, 2018, before your appeal is decided, you will be given, free of charge, any new or additional evidence considered, relied upon, or generated by the claims administrator in connection with your claim. This evidence will be given as soon as possible and sufficiently in advance of the date on which the appeal decision is required to be provided to give you a reasonable opportunity to respond before that date.

Notification of Disability Claim Appeal

If your appeal is denied in whole or in part, the claims administrator will provide you with a written or electronic notification that will include:

- The reasons for the decision, again with reference to the specific plan provisions on which that decision is based
- Your right to receive, upon request and free of charge, reasonable access to and copies of pertinent documents, records, and other information relevant to your claim for benefits
- Your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

In all cases, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either a copy of or statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the determination will be provided free of charge to you upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to your medical circumstances, or a statement that such an explanation is available will be provided to you free of charge upon request.

For claims filed after April 1, 2018, the notice will include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (as applicable) (1) the views that you present of the health care professionals treating you and of the vocational professionals who evaluated you; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination; and/or (3) a determination made by the Social Security Administration that you are disabled.

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- A description of the Plan's limitation period (including the calendar date) for bringing a legal action following a decision on appeal.

Finally, you and the 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.

Foreign Language Assistance

For claims filed after April 1, 2018, if you reside in a county where 10% or more of the population is literate in a non-English language (as determined in accordance with government data), you will be entitled to receive foreign language assistance services with respect to your claim or appeal. The services that you are entitled to receive are described in the health plan claims section.

General Claims Procedures (Non-Health and Non-Disability)

You may file claims for plan benefits, either yourself or via an authorized representative appointed by you or the court. Either you or your authorized representative may appeal an adverse claim decision. Benefit programs that are covered by the General Claim Procedures include the Pension Plan, the 401(k) Savings Plan, the Life and Accident Coverage Plan and the Long-Term Care Plan. In addition even though the dependent care flexible spending account plan is not subject to ERISA, claims related to that program are also handled under these General Claims Procedures.

Initial General Claims (Non-Health and Non-Disability Claims)

If you file a claim for benefits (other than health or disability benefits), you will receive a notice from the Plan Administrator (or claims administrator for non-retirement benefits) regarding the claim according to the procedures described below.

If you file a claim for non-health or non-disability benefits, you will be notified of the plan's benefit determination not later than 90 days after the plan's receipt of the claim. The time period may be extended up to an additional 90 days due to circumstances outside the plan's control. In that case, you will be notified of the extension before the end of the initial 90-day period.

Notification of Initial Claim Decision

The Plan Administrator (or claims administrator for non-retirement benefits) will provide you with a written or electronic notification of any adverse benefit determination, including any claim for plan benefits which is denied in whole or in part, that will include:

- The specific reasons for the denial with reference to the specific plan provisions on which the denial was based
- A description of any additional information needed to complete the claim and an explanation of why such information is necessary
- A description of the plan's claim review and appeals procedures and applicable time limits
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review and within any applicable time limit.

Appeal of a General Claim (Non-Health and Non-Disability Claim)

If your claim is denied or you receive some other type of adverse benefit determination, you may request that it be reviewed. You will have 60 days following receipt of an adverse benefit decision to appeal the decision. If you fail to appeal within this period of time, you may not seek a reconsideration of your claim later, and the initial claim determination or other adverse benefit determination will be final.

To file an appeal, you must submit it in writing to the Benefits Appeals Committee (or for non-retirement benefits to the claims administrator). The contact information for the Benefits Appeals Committee and the claims administrator is located at the end of this Administrative Information section.

You will be notified of the decision no later than 60 days after the appeal is received. If special circumstances require an extension of time of up to an additional 60 days, you will be notified of such extension during the 60 days following receipt of your request. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the plan provide you, free of charge, copies of all documents, records, and other information "relevant" to the claim (as that term is defined in ERISA). The appeal will take into account all documents, records and other information that you submit or that are submitted on your behalf regarding the claim, without regard to whether the information was considered in the initial benefit determination.

Notification of General Claim Decision on Appeal

If your appeal is denied in whole or in part, the Benefits Appeals Committee, Plan Administrator, or claims administrator will provide you with a written or electronic notification that will include:

- The reasons for the decision, again with reference to the specific plan provisions on which that decision is based
- Your right to receive, upon request and free of charge, reasonable access to and copies of pertinent documents, records, and other information relevant to your claim for benefits,
- Your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review, and within any applicable time limit to file the action.

The following table summarizes the deadlines for filing an appeal.

Plan	Appeals
Pantex NB Plan – Pension	Upon receipt of an adverse benefit determination, the Member shall have 180 days following receipt of the notice to request an appeal of the determination.
MTC Plan – Pension	Upon receipt of an adverse benefit determination, the Member shall have 180 days following receipt of the notice to request an appeal of the determination.
PGU Plan – Pension	Upon receipt of an adverse benefit determination, the Member shall have 180 days following receipt of the notice to request an appeal of the determination.
Pantex Non-Bargaining Plan – 401(k)	Upon receipt of an adverse benefit determination, the Member shall have one year following receipt of the notice to request an appeal of the determination.

Plan	Appeals
Pantex Bargaining Plan – 401(k)	Upon receipt of an adverse benefit determination, the Member shall have one year following receipt of the notice to request an appeal of the determination.
Y-12 Plan – Pension	Upon receipt of an adverse benefit determination, the Member shall have one year following receipt of the notice to request an appeal of the determination.
Y-12 Plan – 401(k)	Upon receipt of an adverse benefit determination, the Member shall have one year following receipt of the notice to request an appeal of the determination.

Legal Process

Any legal process relating to a benefit plan should be directed to the plan’s Agent for Service of Legal Process, which is:

CT Corporation System
300 Montvue Road
Knoxville, TN 37919-5546

CT Corporation System
1999 Bryan Street
Suite 900
Dallas, Texas 75201-3136

Legal process may also be served upon the plan trustee (where applicable) or the Plan Administrator.

Plan Termination and Amendment

The Company expects and intends to continue the plans in your benefits program, but reserves its right to amend and/or terminate each of the plans, in whole or in part, without notice. The Company may also increase or decrease its contributions or the participants’ contributions to the plans.

The Company’s decision to terminate or amend a plan may be due to changes in federal or state laws governing pension or welfare benefits, the requirements of the Internal Revenue Code or ERISA, or any other reason. A plan change may result in the transfer of plan assets and liabilities to another plan or split a plan into two or more parts. If the Company does terminate or amend a plan, it may decide to set up a different plan providing similar or identical benefits, but it is under no obligation to do so.

If the Pension Plan or 401(k) Savings Plan is terminated while you are an employee of the Company, you will become immediately vested in your accrued retirement benefit under the Pension Plan or the entire value of your 401(k) Savings Plan account, as applicable.

If a welfare plan is terminated, you will not have any further rights, other than the payment of benefits for covered losses or expenses incurred before the plan was terminated. The amount and form of any final benefit you or your beneficiary receives will depend on any insurance contract provisions affecting the plan and the Company’s decisions.

Special Pension and 401(k) Savings Provisions

There are a few special provisions that apply only to the 401(k) Savings Plan and Pension Plan.

Maximum Benefits

Federal tax laws impose certain limitations on the benefits and contributions under qualified retirement plans. These limitations generally apply only to highly compensated employees. You will be notified if these limitations apply to you. More information is available from the Benefit Plans Office.

Top-Heavy Provisions

Under current tax law, the Pension Plan and 401(k) Savings Plan are required to contain provisions that apply in the event that a significant portion of the plan's benefits are payable to highly compensated employees. These provisions – called “top-heavy” rules – provide for accelerated vesting of plan benefits and certain minimum benefit accruals in the event the plans become top-heavy. The plans are not top-heavy now. The top-heavy rules are not likely to affect your benefits under the plans.

A more detailed explanation of the provisions will be provided if these plans ever become top-heavy.

Assets Upon Termination

If the 401(k) Savings Plan terminates, participants' accounts will be distributed after plan expenses are paid. The trustee will make account distributions as instructed by the Plan Administrator.

Any assets remaining in the Pension Plan after all liabilities to participants and Beneficiary(ies) are satisfied, and after all expenses are paid, will revert to the Company.

Pension Benefit Guaranty Corporation

Your pension benefits under the Pension Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates without enough money to pay all benefits, the PBGC will step in to pay pension benefits, within limits applicable at that time.

The PBGC guarantee generally covers:

- Normal and early retirement benefits
- Disability benefits payable by the Pension Plan if you become disabled before the plan terminates
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates
- Some or all of benefit increases and new benefits-based plan provisions that have been in place for fewer than five years at the time the plan terminates
- Benefits that are not vested because you have not worked long enough for the Company
- Benefits for which you have not met all of the requirements at the time the plan terminates
- Certain Early Retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an Early Retirement monthly benefit greater than your monthly benefit at the plan's Normal Retirement age

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- Non-pension benefits such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has, and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask the Plan Administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Washington, D.C. 20005-4026, or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at <https://www.pbgc.gov>.

Assignment or Alienation of Benefits

Except as required by applicable law (such as a qualified domestic relations order), benefits provided under the Pension Plan and 401(k) Savings Plan are not subject to assignment, alienation, attachment, lien, garnishment, levy, pledge, bankruptcy, execution, or any other form of transfer.

Qualified Domestic Relations Order

A qualified domestic relations order (QDRO) is a legal judgment, decree, or order that recognizes the rights of another individual under the 401(k) Savings Plan or Pension Plan with respect to child or other dependent support, alimony or marital property rights.

In the event of a QDRO, benefits under the Pension Plan and 401(k) Savings Plan may be payable to someone other than your designated Beneficiary to satisfy a legal obligation you may have to a Spouse, former Spouse, child or other dependent. Your Pension Plan or 401(k) Savings Plan benefits will be reduced by the benefits payable under the QDRO to someone else.

There are specific requirements which a domestic relations order must meet to be recognized by the Plan Administrator as a QDRO, and specific procedures regarding the amount and timing of payments. If you are affected by such an order, you will be notified by the Benefit Plans Office. Participants and Beneficiary(ies) may obtain, without charge, a copy of the plan's procedures governing QDROs from the Plan Administrator.

Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is a legal order requiring a parent to provide medical support to a child (for example, in cases of legal separation or divorce). In order to qualify as a QMCSO, the medical support order must be a judgment, decree or order that is issued by an appropriate court or administrative agency and contains certain information. A QMCSO must be provided to the Plan Administrator. A QMCSO must be specific as to the plan, the participant whose child(ren) is (are) to be covered, the type of coverage, the child(ren) to be covered and the length of coverage. The QMCSO may not require the plan to provide coverage for any type or form of benefit, or any option, not otherwise provided under the terms of the plan.

Health Insurance Portability and Accountability Act (HIPAA)

The health plans operate in accordance with regulations under the Health Insurance Portability and Accountability Act (HIPAA) with respect to protected health information (PHI). For purposes of the plans, PHI generally consists of individually identifiable information about you or your dependents, including health and demographic information that relates to your or their eligibility for all group health benefits under the plans. Additional information about your rights under HIPAA is provided separately in a Notice of Privacy Practices.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Coverage for Reconstructive Surgery Following Mastectomy

When a covered individual receives benefits for a mastectomy and decides to have breast reconstruction, based on consultation between the attending physician and the patient, the health plan will comply with coverage requirements by the Women's Health and Cancer Rights Act, to include the following:

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

This coverage must be the same as for any other benefit under the plan.

① Genetic Non-Discrimination Act (GINA)

In accordance with GINA, in no event will the group health plan discriminate against any participant on the basis of genetic information with respect to eligibility, premiums, or contributions.

Compliance with the Affordable Care Act

It is the Company's policy and intent to comply with all applicable provisions of the Affordable Care Act and its related regulations and other governmental guidance. The Company will investigate fully any complaint that the Company or the health plans have not complied with such laws and regulations and will take steps to remedy any violations should they occur. If you believe that the Company or the health plans have violated a provision of the Affordable Care Act, you are encouraged to share your complaint with the Company by contacting the Benefit Plans Office. Please provide as much information as you can regarding your complaint to help the Company with its investigation. The Company will not retaliate or otherwise discriminate against you if you assert a complaint or take any other action which is protected under the Affordable Care Act.

Other Administrative Facts

Specific Plan Information

Plan name	Plan number	Plan type	Plan year
Retirement Program Plan for Employees of Consolidated Nuclear Security, LLC at the U.S. Department of Energy Facilities at Oak Ridge, Tennessee	001	Defined Benefit	Calendar
Retirement Plan for Bargaining Unit Employees of the Metal Trades Council of Consolidated Nuclear Security, LLC	002	Defined Benefit	Calendar
Consolidated Nuclear Security, LLC Retirement Plan for Bargaining Unit Members of the Pantex Guards Union	008	Defined Benefit	Calendar
Consolidated Nuclear Security Retirement Plan for Non-Bargaining Pantex Location Employees	010	Defined Benefit	Calendar
Savings Plan for Employees of Consolidated Nuclear Security, LLC at the U.S. Department of Energy Facilities at Oak Ridge, Tennessee	009	Defined Contribution and 401(k) Plan	Calendar
Consolidated Nuclear Security 401(k) Plan for Bargaining Pantex Location Employees	012	Defined Contribution and 401(k) Plan	Calendar
Consolidated Nuclear Security 401(k) Plan for Non-Bargaining Pantex Location Employees	013	Defined Contribution and 401(k) Plan	Calendar
The Group Welfare Benefit Plan for Employees of Certain Employers of the U.S. Department of Energy Facilities at Oak Ridge, Tennessee provides for the following benefits:			
Group Life Insurance	506	Welfare	Calendar
Business Travel Accident	506	Welfare	Calendar
Special Accident Insurance	506	Welfare	Calendar
Health Benefits (Medical, Dental, Vision, Prescriptions)	506	Welfare	Calendar
Other Consolidated Nuclear Security, LLC Health and Welfare Benefit Plans			
Long-Term Disability	510	Welfare	Calendar
Cafeteria Plan	511	Welfare	Calendar
Employee Assistance Plan	512	Welfare	Calendar
Severance Plan for Salaried Employees	517	Welfare	Calendar

Insurer, Claims Administrator, or Trustee	Source of contributions	Source of benefits
Northern Trust Company serves as Trustee The Northern Trust Company 50 South LaSalle Street Chicago, IL 60675	Employee and Company	Benefits are funded through group annuity contracts and assets in separate investment accounts, all of which are held in one trust
State Street Bank and Trust (serves as Trustee) State Street Bank and Trust P.O. Box 1389 Boston, MA 02104-1389	Employee and Company	Benefits are paid by the Plan Trustee from assets held in the trust
Voya Financial P.O. Box 55772 Boston, MA 02205-5772	Employee	Benefits are funded by employee contributions, which can be Pre-tax, after tax or Roth basis.
Metropolitan Life Insurance Company	Employee/Retiree and Company	Benefits are paid from an insurance contract
Life Insurance Company of North America	Employee and Company	Benefits are paid from an insurance contract
Medical: Administered by Cigna Dental: Administered by Delta Dental of Tennessee Vision: Administered by Vision Service Plan (VSP) Prescription: Administered by Express Scripts	Employee/Retiree and Company	Benefits are paid through claims administrator and paid from employee contributions and general assets of the Company.
Long-term Disability Plan: Cigna Disability (Fully insured)	Employee / Company	Benefits are paid from an insurance contract
Company and an outside claims administrator (Met Life Disability)	Company	Company
Cafeteria Plan Dependent Care Flexible Spending Account Health Care Flexible Spending Account	Employee (Pre-tax contributions)	Benefits are paid (through a claims administrator) from employee contributions and general assets of the Company
Employee Assistance Program – Aetna	Company	Not applicable
Severance Plan for Salaried Employees	Company	Company

Your Rights Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires most employers sponsoring group health plans to offer employees and their eligible family members the opportunity to continue health coverage (called COBRA coverage) in certain circumstances when coverage would otherwise be lost. (For COBRA purposes, a loss of coverage includes an increase in the cost of such coverage.) The plans providing medical, dental, vision, and health care flexible spending account benefits are eligible for COBRA coverage as described in this section. These benefits are referred to in this section as “COBRA Eligible Plans.” This portion of the Administrative Information section is considered your “Initial COBRA Notice” and generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

Certain aspects of COBRA continuation coverage are administered by Allegiance COBRA Services, Inc., which is referred to in this Section as the “COBRA Administrator.” The contact information for the COBRA Administrator is:

Plan Administrator
Consolidated Nuclear Security, LLC
PO Box 2115
602 Scarboro Road
Oak Ridge, TN 37831-2115
(865) 574-1500
(877) 861-2255

COBRA continuation coverage is a continuation of coverage under the COBRA-Eligible Plans when coverage would otherwise be lost because of a life event known as a Qualifying Life Event. Specific Qualifying Life Events are identified below. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified Beneficiary is someone who will lose coverage under a COBRA-Eligible Plan because of a Qualifying Life Event. Depending on the type of Qualifying Life Event, employees, Spouses of employees, and dependent Child(ren) of employees may be qualified Beneficiary(ies). Qualified Beneficiaries who elect COBRA continuation coverage will be required to pay for COBRA continuation coverage.

In addition to COBRA continuation coverage, you may have other 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 does not accept late enrollees. Additional information is provided below.

Eligibility and Coverage

You will become a qualified beneficiary if you lose your coverage under COBRA-Eligible Plan because either one of the following qualifying events happens:

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

Your covered Spouse will become a qualified beneficiary if he or she loses coverage under a COBRA-Eligible Plan because any of the following Qualifying Life Events happens:

- You die;
- Your hours of employment are reduced;

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- Your employment ends for any reason other than your gross misconduct; or
 - You and your Spouse divorce.

Also, if you reduce or eliminate your Spouse's coverage under a COBRA-Eligible Plan in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a qualifying event for your Spouse even though his or her coverage was reduced or eliminated before the divorce.

Your covered dependent Child(ren) will become qualified Beneficiaries if they lose coverage under a COBRA-Eligible Plan because any of the following Qualifying Life Events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You and your Spouse divorce; or
- The Child stops being eligible for coverage under the Plan as a "dependent child."

Child(ren) born to or placed for adoption with you during the continuation coverage period may also elect continuation coverage, as long as you have elected COBRA coverage for yourself. The coverage period will be determined according to the date of the Qualifying Life Event that gave rise to your COBRA coverage.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Life Event. If a proceeding in bankruptcy is filed with respect to the Company and that bankruptcy results in the loss of coverage of any retiree employee coverage by a COBRA-Eligible Plan, the retired employee will become a qualified Beneficiary with respect to the bankruptcy. The retired employee's covered surviving Spouse, and covered dependent Child(ren) will also become qualified Beneficiaries if the bankruptcy results in the loss of their coverage under a COBRA-Eligible Plan.

Special rules apply to the health care flexible spending account. You and/or your Eligible Dependent(s) will be able to continue coverage under the health care spending flexible account only if the maximum benefit available to you or your Eligible Dependent(s) for the remainder of the plan year is equal to or more than the maximum amount that you could be required to contribute to the health care flexible spending account for the remainder of the plan year.

Required Notice of Qualifying Events

Under the law, you or a covered Eligible Dependent (or a representative) has the responsibility to inform the Plan Administrator of an initial Qualifying Life Event, such as a divorce or a Child's loss of dependent status under the COBRA-Eligible Plan. To be eligible for continued coverage, you or your covered Eligible Dependent (or a representative) must inform the Benefits Plan Office within 60 days after the later of the event or the date on which coverage would otherwise end because of the event. In addition, in the event of the birth or adoption of a Child after the Qualifying Life Event, you must notify the COBRA Administrator of the birth or adoption of the Child whom you wish to enroll under the COBRA-Eligible Plan. The notice procedures are described below. (The Company must notify the COBRA Administrator of your death, termination of employment or reduction in work hours). If this notice is not timely and properly provided, the qualified Beneficiary will not be permitted to elect COBRA continuation coverage.

COBRA Election Period

Once the COBRA Administrator receives notice that a Qualifying Life Event has occurred, COBRA continuation coverage will be offered, when appropriate, to each of the qualified Beneficiary(ies). Each qualified Beneficiary will have an independent right to elect COBRA continuation coverage for 60 days from the later of the date coverage is lost under the COBRA-Eligible Plan or the date of notification to elect continuation coverage.

To inform the COBRA Administrator that you want COBRA continuation coverage, you must complete the election form and submit it to the COBRA Administrator as directed in the COBRA election notice. If mailed, the election form must be postmarked no later than sixty 60 days after the date of the COBRA election notice provided at the time of the Qualifying Life Event. The following are not acceptable as COBRA elections and will not preserve your COBRA rights: oral communications, including in-person or telephonic statements about an individual's COBRA coverage, and electronic communications (other than by enrolling on-line).

You may elect COBRA continuation coverage on behalf of your eligible Spouse, and you or your Spouse may elect COBRA continuation coverage on behalf of your eligible Child(ren). If you or your eligible Spouse elects COBRA continuation coverage without specifying whether the election is for self-only coverage, the election will be considered to be made on behalf of all other qualified Beneficiary(ies) with respect to that Qualifying Life Event.

Special COBRA rights may apply if you lose coverage because of termination of employment or a reduction in hours of employment and you qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 2002. Generally, in this situation, you may be entitled to a second opportunity to elect COBRA continuation coverage for yourself and certain family members (if you did not already elect COBRA continuation coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after your initial loss of coverage. In addition, eligible individuals can take a tax credit equal to 72.5% of the premiums paid for qualified health insurance, including COBRA coverage. Eligible individuals who elect to claim this tax credit will not be eligible for a premium subsidy through the Marketplace.

If you qualify or may qualify for assistance under the Trade Act, please contact the Benefits Plan Office for additional information. You must contact the Benefits Plan Office promptly after qualifying for assistance under the Trade Act or you will lose these special COBRA rights. More information can be found by visiting www.doleta.gov/tradeact or www.irs.gov/HCTC.

When making the decision of whether to elect COBRA continuation coverage, you should keep in mind that you may have other options. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov or by calling 1-800-318-2596.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible. When you lose job-based health coverage, it is important that you choose carefully between COBRA continuation coverage and other coverage options, because once you have made your choice, it can be difficult or impossible to switch to another coverage option.

Additional information is provided below.

Description and Maximum Length of COBRA Coverage

If you continue coverage, you will receive coverage identical to that provided under the COBRA-Eligible Plan for similarly situated employees or family members. If the Company changes the benefits provided under a COBRA-Eligible Plan during your COBRA continuation period, your COBRA continuation coverage will also be changed in the same manner.

COBRA continuation coverage is a temporary continuation of coverage and may only be continued for certain specified time periods depending upon the Qualifying Life Event. If you or your Eligible Dependent(s) elect to continue coverage under the health care flexible spending account, participation may continue only until the end of the year in which the Qualifying Life Event occurs. With respect to continuation coverage for all other COBRA-Eligible Plans, the time periods are described in general below.

- **36-Month Period.** When the Qualifying Life Event causing loss of coverage is your death, your divorce, or a Child losing eligibility as a dependent Child, COBRA continuation coverage lasts for up to a total of 36 months. If the Qualifying Life Event is your death and your Eligible Dependent receives extended coverage under the medical plan (as described in the Medical Plans section), the maximum COBRA period will be reduced by the length of that extended coverage.
- **18-Month Period.** When the Qualifying Life Event causing loss of coverage is the end of your employment or reduction in your hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. However, if you became entitled to Medicare benefits less than 18 months before your termination or reduction in hours of employment, COBRA continuation coverage for other qualified Beneficiary(ies) lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare eight months before your employment terminates, COBRA continuation coverage for your Spouse and Child(ren) can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Life Event (36 months minus 8 months).

If you become entitled to Medicare or first learn that you are entitled to Medicare after submitting your Election Form, you must notify the COBRA Administrator of the date of your Medicare entitlement at the address specified herein. The notice procedures are described below.

The maximum COBRA coverage period for your newborn or newly-adopted Child is measured from your original Qualifying Life Event. To be enrolled in a COBRA-Eligible Plan, the Child must satisfy the otherwise applicable plan eligibility requirements. A person who becomes the Spouse of a qualified Beneficiary (including a new Spouse of an employee) or dependent Child of a qualified Beneficiary (other than one born to or placed for adoption with an employee) during COBRA continuation is not a qualified Beneficiary and may not extend COBRA if a second event results in the loss of COBRA coverage.

Described below are two ways in which the general 18-month period of COBRA continuation coverage can be extended.

- **Disability extension of 18-month period of continuation coverage:** If you or anyone in your family covered under the COBRA-Eligible Plan is determined by the Social Security Administration to be disabled and the COBRA Administrator is notified in a timely fashion, you and your family members who are receiving COBRA coverage may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The Social Security Administration must determine that the disability started at some time before the 60th day of COBRA continuation coverage, and the disability must last at least until the end of the regular 18-month period of continuation coverage. In order to qualify for the extension, you or the disabled qualified Beneficiary (or a representative) must notify the COBRA Administrator in writing of the Social Security Administration's determination before

the end of the 18-month period of COBRA continuation coverage and within 60 days after the later of (1) the date the qualified Beneficiary is determined to be disabled by the Social Security Administration; (2) the date you terminated or reduced your hours of employment; and (3) the date on which the qualified Beneficiary would lose coverage under the plan as a result of your termination or reduction in hours of employment. The procedures for providing this notice are described below.

- **Second qualifying event extension of 18-month period of continuation coverage:** If your family experiences another Qualifying Life Event while receiving 18 months (or 29 months in case of a disability extension) of COBRA continuation coverage, your Spouse and your Child(ren) in your family can get additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Life Event is properly given to the COBRA Administrator. This extension may be available to your Spouse and any Child(ren) receiving continuation coverage if you die or divorce, or if your Child stops being eligible as a dependent Child, but only if the event would have caused your Spouse or Child to lose such coverage under the plan had the first Qualifying Life Event not occurred. In no event may a Qualifying Life Event give rise to a maximum coverage period that ends more than 36 months after the date of the first Qualifying Life Event. For cases of second Qualifying Life Events, the qualified Beneficiary must notify the COBRA Administrator in writing within 60 days after the later of (1) the date of the second Qualifying Life Event; or (2) the date on which the qualified Beneficiary would have lost coverage under the plan due to the second Qualifying Life Event if it had occurred before the first Qualifying Life Event. The procedures for providing this notice are described below.

Failure to provide timely and properly provide notice of a disability determination or second Qualifying Life Event will eliminate the right to extend the period of COBRA coverage.

Termination of COBRA Coverage

COBRA coverage will terminate before the end of the indicated time period if any one of the following events occurs:

- The qualified Beneficiary receiving COBRA coverage becomes covered under another group health plan after electing COBRA (provided the plan does not have pre-existing condition exclusions affecting the covered individuals; if the other plan has such limitations, COBRA coverage will end when those limitations expire).
- The qualified Beneficiary receiving COBRA coverage becomes entitled to Medicare after electing COBRA continuation coverage.
- The first required premium is not paid within 45 days or any subsequent premium is not paid within 30 days of the due date.
- If coverage is extended beyond 18 months because of disability, the Social Security Administration makes a final determination that the qualified Beneficiary is no longer disabled.
- The Company terminates its group health plans.

If, during the period of COBRA coverage, a qualified Beneficiary becomes covered, after electing COBRA, under other group health plan coverage, you or the qualified Beneficiary (or a representative) must notify the COBRA Administrator in writing within 30 days of the later of:

- the date the other coverage becomes effective, or
- the exhaustion or satisfaction of any preexisting condition exclusions affecting the qualified Beneficiary.

If, during the period of COBRA coverage, a qualified Beneficiary becomes entitled, after electing COBRA, to Medicare Part A, Part B, or both, you or the qualified Beneficiary (or a representative of either) must notify the COBRA Administrator in writing within 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

If the Social Security Administration determines that a qualified Beneficiary is no longer disabled, COBRA coverage for all qualified Beneficiary(ies) will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the date of the determination. The qualified Beneficiary must notify the COBRA Administrator in writing within 30 days after the Social Security Administration's determination that he or she is no longer disabled.

The procedures for providing this notice in both of these circumstances are described below.

If notice of these events is not timely and properly provided, the qualified Beneficiary's COBRA coverage may be terminated retroactively and the qualified Beneficiary may be required to repay a portion of the benefits received.

A qualified Beneficiary does not have to show that he or she is insurable to choose COBRA continuation coverage. However, COBRA coverage is provided subject to the qualified Beneficiary's eligibility for coverage. The COBRA Administrator reserves the right to terminate a qualified Beneficiary's COBRA coverage retroactively if he or she is determined to be ineligible.

Premium Payments

A qualified Beneficiary who elects coverage will be charged a premium of no more than 102% of the total cost of providing coverage. The premium for a Social Security disabled person can be as much as 150% of the cost of coverage for the 19th through the 29th month of coverage.

The Benefit Plans Office will notify you by mail of your COBRA election rights when the Qualifying Life Event is a reduction in hours or termination of employment. You will receive instructions on how to continue your health care benefits under COBRA.

If your dependents lose coverage due to divorce, legal separation or loss of dependent status, you (or a family member) must notify the Benefit Plans Office within 60 days of the event so that COBRA can be offered and your election rights can be mailed to you. Also, to extend coverage beyond 18 months because of disability, however, notice of the Social Security Administration's determination must be provided within 60 days after you receive that determination and before the end of the initial 18-month period.

Notice Procedures

As a condition of receiving COBRA coverage, you or your covered dependent (or a representative) must notify the Plan Administrator or COBRA Administrator when certain events occur which impact COBRA continuation coverage. These COBRA-related events include:

- Certain initial Qualifying Life Events
- Second Qualifying Life Events
- A qualified Beneficiary's determination of disability or cessation of disability
- Enrollment in another group health plan while receiving COBRA coverage
- Medicare entitlement while receiving COBRA coverage

Each of these events, including the time period for providing notice of the event, has been discussed previously. Unless directed otherwise in the COBRA election notice (if applicable):

- All other notices, including notice of a second Qualifying Life Event or a qualified Beneficiary's determination or cessation of disability, must be provided to the COBRA Administrator. The notice must contain the name, address and phone number of the covered employee (or formerly covered employee) and/or each qualified Beneficiary experiencing the COBRA-related event, the name of the COBRA-Eligible Plan, the COBRA-related event being reported and the date of such event. You must also provide evidence that the COBRA-related event has occurred. Acceptable evidence is your signed certification that the event has occurred, except in the case of a Social Security disability determination. For a Social Security disability determination, you must provide a copy of your Social Security Disability Award letter, or if you are no longer disabled, you must provide a copy of the Social Security's determination that you are no longer disabled.

If mailed, the notice must be postmarked no later than the applicable deadline for giving the notice. If the notice is timely and properly provided, the notice will be deemed to have been provided on behalf of all qualified Beneficiaries who are required to give the notice.

Additional documentation supporting the notice may be required. If such information is requested and it is not provided within 15 business days of the request, the notice will not be considered timely and continuation coverage may not be available.

Keep the Plan Informed

In order to protect your family's rights, you should keep the Company and the COBRA Administrator informed of any changes in the addresses of your family members. If you have changed your marital status, or you or your Eligible Dependents have changed addresses, it is your responsibility to notify the COBRA Administrator. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

Health Insurance Marketplace

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you will also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

There are time limits on enrolling in Marketplace coverage. You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll until annual enrollment, so you should take action right away if you think that you may want Marketplace coverage. In addition, you may also enroll in Marketplace coverage annually during what is called an "open enrollment" period. The open enrollment period is the time during which anyone can purchase coverage through the Marketplace.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If you enroll in COBRA Coverage, it may temporarily limit your Marketplace options. If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a “special enrollment period.” If, however, you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if you enroll outside of the Marketplace open enrollment.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Enrolling in another Group Health Plan

You may be eligible to enroll in coverage under another group health plan (like a Spouse’s plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you are eligible, you will have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

Factors to Consider when Choosing Coverage Options

When considering your options for health coverage, you may want to think about:

- **Premiums:** You can be charged up to 102% of total plan premiums for COBRA coverage (more if you qualify for an extension of coverage on account of a disability). Other options, like coverage on a Spouse’s plan or through the Marketplace, may be less expensive.
- **Provider Networks:** If you are currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- **Drug Formularies:** If you are currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Severance Payments:** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. Keep in mind that when these payments stop, you will be required to pay the full COBRA premiums until you are allowed to enroll in the Marketplace which, in many cases, will not be until the next annual enrollment.
- **Service Areas:** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

If You Have Questions

Questions concerning your Medical Benefit Option or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.HealthCare.gov.

Your Rights under FMLA and USERRA

Leave Taken Under the FMLA

If you are covered under a group health plan (including the medical plan, dental plan, vision plan, employee assistance program, or health care flexible spending account) and you take leave under the Family and Medical Leave Act of 1993, as amended (FMLA), you and your Eligible Dependents' coverage will continue under the plans to the extent required by the FMLA (that is, the Company will continue to pay its share of the contributions required and you must continue to make your contributions). If your coverage ceases during the FMLA leave (for example, because you opted not to continue coverage or due to nonpayment of your contributions), you may resume your coverage upon return from FMLA leave on the same terms as before the leave was taken, or as required by the FMLA. Under special rules that apply if you do not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA continuation coverage even if they were not covered under one of the group health plans during the leave. Please contact the Plan Administrator for more information about these special rules.

Leave Taken Under the USERRA

If you are covered under a group health plan, including the medical plan, dental plan, vision plan, employee assistance program, or health care flexible spending account, and are going into or returning from military service, you will have certain rights mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended. As used herein, military service means service in the Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

In particular, you have the right to continued coverage under the group health plans provided you give advance notice of your service unless it is impossible or unreasonable under the circumstances to give such notice or giving such notice is precluded by military necessity. Coverage may be continued until the earlier of (1) 24 months after your absence from work begins, or (2) the day after the date on which you fail to timely apply for or return to employment as required under USERRA. If you elect to continue coverage, you must timely notify the Plan Administrator of your election to continue coverage.

Your right to continued health coverage under USERRA is very similar, but not identical, to your right to continued health coverage under COBRA. In those instances where your rights under COBRA and USERRA are not the same, whichever law gives you the greater benefit will apply. The administrative policies and procedures which govern your right to COBRA continuation coverage also apply to your right to USERRA continuation coverage with a few limited exceptions.

Any election that you make under COBRA will also be an election to continue your health coverage under USERRA. If, however, you are unable to elect COBRA within the required period because of

military necessity or because it is impossible or unreasonable for you to do so, the period for electing USERRA coverage will be tolled until the military necessity is abated or it is no longer impossible or unreasonable for you to make the required election. The period for electing COBRA coverage, however, will not be tolled in this situation.

You are the only one that has the right to make an election under USERRA to continue health coverage for yourself and any covered dependents. Your covered dependents do not have an independent right to make an election for USERRA continuation coverage. As a result, if you do not elect USERRA / COBRA coverage on behalf of your covered dependents, your covered dependents will still have a right to elect to continue their health coverage under COBRA, but they will not be entitled to receive any additional benefits provided under USERRA.

If your military service is less than 31 days, you are required to pay only your normal share of the contribution for such coverage. If the length of your military service extends past 31 days, the Plan Administrator may require you to pay up to 102% of the contribution cost for coverage for similarly situated covered individuals who are not serving in a military service.

Plan exclusions may be imposed for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

If you are called to active military duty, you and your Eligible Dependents may be eligible for coverage under Tricare, the military service's health plan. You and your Eligible Dependents may also elect to continue benefits under the Company's group health plan if you were covered by such plan at the time you were called to military duty.

If you choose not to continue coverage during your military service, you and your Eligible Dependents are eligible for reinstatement of coverage on the date you return with reemployment rights guaranteed under USERRA. As permitted by USERRA, your coverage will not include any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of military service. Any other such illness or injury will be covered, subject to all otherwise applicable conditions and limitations of the plan.

As noted above, your USERRA continuation coverage will generally continue for up to 24 months following the date your leave of absence begins, but it could end earlier for any of the following reasons:

- You fail to pay the required premium on time
- You fail to return work within the time required under USERRA following the completion of your service
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

After your USERRA continuation coverage expires, you will not thereafter receive continuation of coverage under COBRA. However, if your USERRA coverage expires prior to the expiration of the continuation of coverage under COBRA (e.g., because you do not return to employment), you may be eligible for continuation of coverage under COBRA for the remainder of the original COBRA coverage period.

The above is only a summary of the FMLA and USERRA rights and limitations. If you wish to elect FMLA or USERRA coverage or obtain more detailed information, please contact the Plan Administrator.

Your Rights under ERISA

As a participant in any of the Company's benefit plans described in this book, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office, all plan documents.
- Obtain, upon written request to the Plan Administrator, copies of all plan documents and other plan information. The Plan Administrator may charge a reasonable fee for copies.
- Receive a summary annual report of the plan's financial activities. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition, you may request information concerning the total value of your 401(k) Savings Plan accounts by logging on to the recordkeeper's website or calling the recordkeeper. You may also receive a quarterly statement showing the value of your account, type of contributions and the amount that is vested.

Similarly, once each year, you may request information concerning your vested rights under the Pension Plan (or, if you are not vested, the earliest date on which you become vested), and what your benefit would be at Normal Retirement age if you stopped working under the plan now. This information is free of charge, but you must address a written request for it to the Plan Administrator or, for 401(k) Savings Plan information, call the Information line.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Spouse or Eligible Dependents if there is a loss of coverage under the plans as a result of a Qualifying Life Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

- In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your plans, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants, and Beneficiary(ies).
- No one, including your Employer, your union, or any other person, may fire you, or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

- If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan, and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the 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, which is denied or ignored, in whole or in

part, you may file suit in a state or federal court. However, in no event will you be allowed to file suit until you have exhausted the administrative remedies available under the plans, including following the appropriate claims procedure as described above.

- In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.
- If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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