SUMMARY PLAN DESCRIPTION SUPPLEMENT

TO THE

EVRAZ NORTH AMERICA

EMPLOYEE BENEFIT PLAN

Effective January 1, 2018

This document combined with the applicable Benefit Descriptions (listed in Attachment A to this document) constitutes the summary plan description required by ERISA § 102.

INTRODUCTION

Evraz North America (the "Employer") is proud to sponsor the Evraz North America Employee Benefit Plan (the "Plan") which we have established to provide Welfare Benefit Programs to Eligible Employees of the Employer, and any other Adopting Employers, and their Dependents, if applicable. The Plan was most recently restated effective as of January 1, 2017, and provides the following Welfare Benefit Programs: medical, dental, vision, long-term disability, short-term disability, group life insurance, health care flexible spending account ("FSA Plan"), health savings account ("HSA Plan"), dependent care assistance program ("Dependent Care Reimbursement Plan"), employee assistance program, and retiree health reimbursement benefits. This document supplements the Benefit Descriptions (i.e., the insurance booklets and benefit summaries, etc.) of each Welfare Benefit Program and should be kept with your Benefit Description(s).

You should refer to your Benefit Description for the complete details on the benefits provided for the applicable Welfare Benefit Program. This document together with the Benefit Description(s) of the applicable Welfare Benefit Program constitutes the Summary Plan Description ("SPD") under Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). A list of the Benefit Descriptions for each Welfare Benefit Program is provided in Appendix A to this document and will be updated from time to time by the Plan Administrator.

Please contact the Plan Administrator at (312) 533-3555 if you have any questions regarding this document.

IMPORTANT DISCLAIMER: Only the Plan document and Benefit Descriptions confer benefits rights, and therefore the Plan document and Benefit Descriptions shall control in all matters, including where there is a discrepancy between this document and the governing Plan document or any Benefit Description. In addition, note that Employees who are subject to a collective bargaining agreement ("CBA") should consult their applicable CBA for additional information regarding eligibility and benefits.

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I. DEFINITIONS

If there is any conflict between the following definitions and those found in the underlying Benefit Descriptions for each applicable Welfare Benefit Program, the definitions in the Benefit Descriptions control.

"**Adopting Employer**" means a company related to the Employer that has elected to offer Plan benefits to its employees with the consent of the Plan Sponsor.

"**Benefit Descriptions**" means written descriptions of the Welfare Benefit Programs listed in Section III. These may include insurance benefit booklets or summaries, insurance policies and certificates of coverage, and any other additions, substitutions, and/or modifications that is applicable to the particular Welfare Benefit Program. The Benefit Descriptions are a part of and incorporated into this document. See Attachment A or contact the Plan Administrator for a list of the applicable Benefit Descriptions.

"**Claims Administrator**" means the Insurer (or its authorized agent) for those Welfare Benefit Programs that are fully insured or the third party administrator designated by the Employer for those Welfare Benefit Programs that are self-insured.

"**Dependent**" means your Spouse, children up to age 26, or other dependent children who became incapable of self-support due to mental or physical disability prior to age 26, unless otherwise provided in the applicable Benefit Description.

"**Eligible Employee**" means an Employee who is classified as a regular full-time employee or a part-time employee who regularly works 20 or more hours per week. The term "Eligible Employee" does not include individuals who are in a job classification designated by the Employer as not benefits eligible, regardless of the individual's work schedule, number of hours worked, or a later determination by a court or government agency that the individual is an employee for tax or other related purposes**.** In particular, but without limitation, the term "Eligible Employee" does not include individuals who are classified as "loan-outs," "leased employees," or "independent contractors."

"**Employer**" means Evraz North America and any successor. Depending on the context, "Employer" also may refer to the Plan Sponsor and/or any other Adopting Employer. And while either the Plan Sponsor or an Adopting Employer may terminate the Adopting Employer's participation in the Plan, only the Plan Sponsor may amend and terminate the Plan.

"**Insurer**" means an insurance company providing insured benefits under the Plan.

"**Participant**" means any Eligible Employee or his Dependents covered under this Plan.

"**Plan**" means the Evraz North America Employee Benefit Plan, which includes the Welfare Benefit Programs listed in Section III and described in the Benefit Descriptions, which are incorporated by reference and listed in Appendix A.

"**Plan Administrator**" means the Plan Sponsor or other third party designated by the Plan Sponsor, which may include an insurance company for insured benefits.

"**Plan Sponsor**" means Evraz North America or its successor.

"**Plan Year**" means the calendar year.

"Spouse" means the individual to whom the Eligible Employee is lawfully married or, in the case of a deceased Eligible Employees, was lawfully married under the laws of the jurisdiction in which the marriage was entered into and is recognized, consistent with applicable U.S. federal law.

"**Welfare Benefit Program**" means any benefit plan or program that is part of this Plan as listed in Section III.

II. IMPORTANT CONTACT INFORMATION

Below is the website and phone number for the vendors that provide various services and/or insurance benefits for the Plan. Updated contact information also will be available at your benefits website at www.HRConnection.com and will be included with annual open enrollment materials.

Related Benefit	Service Provider	Website	Phone Number
Medical	Highmark BCBS Kaiser Permanente	www.highmarkbcbs.com www.healthy.kaiserpermanente.org	866-217-5067 800-813-2000
Dental	Delta Dental/Moda Kaiser Permanente	www.deltadental.com www.kp.org	888-217-2365 800-813-2000
Vision	VSP	www.vsp.com	800-877-7195
FSA Plan	Benefit Resource	www.benefitresource.com	800-473-9595
Employee Assistance Program	Magellan EAP	www.magellanhealth.com/member	800-523-5668
HSA Plan	Benefit Resource HSA	www.benefitresource.com	800-473-9595
Life and AD&D	Standard	www.standard.com	800-628-8600
Voluntary Life	Standard	www.standard.com	800-628-8600
Short-term Disability	Standard	www.standard.com	800-628-8600
Long-term Disability	Standard	www.standard.com	800-628-8600
Retiree Health Reimbursement	Alight Smart Choice	www.smartchoiceaccounts.com/evraz	833-769-4785
COBRA	Benefit Resource	www.benefitresource.com	800-473-9595

III. PLAN BENEFITS

3.1 Welfare Benefit Programs

The Welfare Benefit Programs under this Plan are provided as set out in the Plan document and are described in this document and the applicable Benefit Descriptions for each particular Welfare Benefit Description. Current copies of the Benefit Descriptions either already have been or will be provided to you. If you misplaced your copy of any Benefit Description, you may contact the Plan Administrator to have them replaced or visit www.HRConnection.com to

download/print an additional copy. This Summary Plan Description describes the following benefits:

(a) Medical

(b) Dental

(c) Vision

(d) Long-Term Disability

(e) Short-Term Disability

(f) Accidental Death & Dismemberment ("AD&D") Insurance

(g) Group Life Insurance Benefits (including supplemental life and optional voluntary life insurance)

(h) Employee Assistance Program

(i) Cafeteria Plan benefits, including the HSA Plan, FSA Plan, and Dependent Care Reimbursement Plan

(j) Retiree Health Reimbursement Plan

3.2 Limitations, Exclusions and Restrictions on Welfare Benefit Programs

The Benefit Descriptions of each Welfare Benefit Program described above contain separate descriptions as to limitations, exclusions, and restrictions on benefits for that particular Welfare Benefit Program.

IV. PLAN ADMINISTRATION

4.1 Plan Contributions

Generally, Eligible Employees contribute a portion of their salary on a pre-tax basis (as described in Article VI) to pay for the cost, in part, of certain Plan benefits. The Employer generally provides schedules of required contributions for Plan coverage in advance of the Plan Year. The Employer reserves the right to amend the Plan to require or change the amount of contributions required from Employees.

4.2 Plan Funding

Plan funding is provided through Employee contributions, the Employer's general assets, or a combination of both. Group insurance contracts with Insurers provide for the following Welfare Benefit Programs: vision, certain dental, long-term disability, group term life, AD&D, and certain medical insurance. Certain group medical and dental, short-term disability, and retiree health reimbursement benefits are self-insured and are funded through the Employer's general assets.

4.3 Plan Administrator's Duties and Discretion

The Plan Administrator must discharge its duties under the Plan solely in the interest of the Participants, and for the exclusive purpose of providing benefits to such persons and defraying the reasonable expenses of administering the Plan. The Plan Administrator may delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate. The Plan Administrator also has the sole discretionary authority and responsibility, unless otherwise delegated to a third party, to construe, interpret, and administer the Plan in accordance with its terms, including the right to remedy possible ambiguities, inconsistencies, or omissions. No claims for benefits will be paid unless the Plan Administrator or Claims Administrator determines that the Participant is entitled to them. Any determination by the Plan Administrator or the respective Claims Administrator is final and binding.

4.4 Power and Authority of the Insurer

Claims for benefits provided under a group insurance contract between the Employer and an Insurer are sent to the applicable Insurer. In that case, the Insurer, not the Employer, is responsible for determining and paying claims. The applicable Insurer is the named fiduciary for benefit claims and is responsible for determining eligibility for a benefit and the amount of any benefits payable under the Plan, establishing the claims procedures to be followed, and providing claims forms. The applicable Insurer also has the authority to require eligible individuals to furnish it with such information as it determines is necessary for the proper administration of the Plan.

V. ELIGIBILITY, PARTICIPATION, TERMINATION AND CONTINUATION

Note: The following provisions supplement the eligibility provisions set forth in the Benefit Descriptions; please see the Benefit Descriptions for additional eligibility and enrollment requirements and information.

5.1 Eligibility and Commencement of Employee Coverage

If you meet the definition of an Eligible Employee, you will be eligible for the benefits provided under the terms of the respective Benefit Description. Eligibility requirements for the Welfare Benefit Programs may vary among Employees and depend upon whether you are a salaried or hourly Employee, union or non-union, and where you work. For your specific eligibility requirements and waiting periods, please visit www.HRConnection.com and enter the login information provided in your applicable benefits guide, which is provided to you upon your becoming eligible for benefits, and annually at open enrollment. If you need a new benefits guide, please contact your Human Resources Representative.

If you are an Eligible Employee, you will begin participation on the first day that you are eligible if you complete the required enrollment by the deadline given. If you choose not to enroll in the Plan within that timeframe, you may enroll only during an annual open enrollment period unless otherwise permitted for certain changes in circumstances. See Sections 5.3 and 6.2 for an explanation of those special enrollment rights.

The Plan Administrator has the authority to verify the eligibility of all Participants and Dependents and may use any reasonable methods of doing so including, but not limited to, collecting supporting documentation (i.e., marriage certificates, birth certificates, etc.) or conducting eligibility audits to verify eligibility. Failure to provide verification of relationship or dependent status upon request or as part of such an audit may lead to a termination of eligibility subject to the discretion of the Plan Administrator.

Notwithstanding anything herein to the contrary, your eligibility for benefits does not constitute an employment contract or otherwise confer upon you any additional rights with respect to your employment.

Employees who are subject to a collective bargaining agreement should consult that CBA for additional information regarding eligibility and benefits.

5.2 Commencement of Dependent Coverage

If your Dependents satisfy the requirements in the applicable Benefit Descriptions regarding Dependent coverage, their coverage will begin at the same time as your coverage, assuming you submit a timely enrollment form for them. Otherwise, their coverage may begin as of the next January 1st provided you submit a timely enrollment form for them during open enrollment, or at the time described below in connection with a special enrollment event.

The annual open enrollment for the Plan generally begins in the fall preceding the start of each calendar year for which benefits elected and elections made during open enrollment generally will take effect.

5.3 Special Enrollment Rights

You and your Dependents may be eligible to enroll in those Welfare Benefit Programs that provide medical benefits outside of the annual open enrollment period during a "special enrollment period" as required under the federal Health Insurance Portability and Accountability Act ("HIPAA") and described in the applicable Benefit Description. Specifically, you and/or your Dependents may be able to enroll in the medical benefits if:

(a) you or your Dependent experiences a loss of other group health plan coverage (including Medicaid or a state children's health insurance program ("SCHIP"));

(b) you or your Dependent loses eligibility for coverage in the individual market, including coverage purchased through a Marketplace established under the Patient Protection and Affordable Care Act of 2010, as amended ("ACA"), (other than loss of eligibility for coverage due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact);

(c) you gain a Dependent through birth, adoption, placement for adoption or marriage; or

(d) you or your Dependent becomes eligible for a state premium assistance subsidy from Medicaid or SCHIP.

Generally, you must complete the applicable enrollment materials within 31 days of the special enrollment event in order to enroll in the medical benefits. However, if the special enrollment event occurs as a result of losing Medicaid or a SCHIP coverage or becoming eligible for a state premium assistance subsidy under Medicaid or SCHIP, you must request enrollment within 60 days of the applicable event.

5.4 Commencement of Retiree Coverage

Following employment, certain Employees may be eligible for retiree health reimbursement coverage as set forth in the applicable retiree benefit plan document. Coverage shall commence as of the date set forth in the retiree health Welfare Benefit Program

5.5 Termination of Participation

Your benefits (and the benefits of your Dependents) will cease when your participation in the Plan terminates. Coverage may be terminated for you or your Dependent(s) if any one of the following events occurs:

(a) you terminate employment with the Employer;

(b) the number of hours you are regularly scheduled to work is reduced so that you are no longer eligible to participate in the Plan;

(c) you and/or your Dependent(s) cease to meet Plan eligibility requirements;

(d) you or your Spouse become a full-time member of the armed forces of any country (unless required by applicable law);

(e) you cease to pay any required premium(s);

(f) you and/or your Dependent(s) commits an act of fraud or a material misrepresentation;

(g) the Plan, or a Welfare Benefit Program, is terminated; or

(h) as otherwise described in the applicable Benefit Description or the Plan.

5.6 Fraud

If you or your Dependent(s) deliberately defraud or mislead the Plan Administrator about the eligibility or entitlement to Plan benefits of yourself or another person, the Plan Administrator has the right to terminate the Plan coverage provided to you and/or your Dependent(s) immediately (and retroactively upon 30 days' notice). The Plan shall be entitled to recover (including by means of offset against future benefits) from you and/or your Dependent(s) any claims mistakenly paid due to mistake, fraud or a wrongful attempt to procure coverage, and to

recover any costs and expenses arising from such fraud or misrepresentation, including, but not limited to, costs and expenses recoverable in a lawsuit. Additionally, fraud on the part of the Employee shall be grounds for disciplinary action up to and including termination of employment.

5.7 Reinstatement Following Termination of Employment

If you terminate employment and remain terminated for less than 31 days before becoming an Employee of the Employer again, you will be reinstated as a Participant under the Plan under the same terms as you enjoyed prior to your termination. If your employment is terminated 31 days or more before you become an Employee of the Employer again, you must enroll in the Plan in the same manner as any Employee who has never been a Participant under the Plan.

VI. CAFETERIA PLAN

Through the Cafeteria Plan component of the Plan you can elect to participate in the following benefits:

- Premium Payment Plan
- FSA Plan
- Dependent Care Reimbursement Plan
- HSA Plan

These are separate benefits. Your election to be covered under any one benefit will not obligate you to participate in any of the other benefits.

Participation in the Plan allows you to make contributions (that are withheld from your paychecks) to a pre-tax Premium Payment Plan account to pay for your share (if any) of the cost of your participation in certain of the Employer's group Welfare Benefit Programs on a pre-tax basis. Participation also allows you to make contributions (also via paycheck withholding) that go into the reimbursement accounts for reimbursement of eligible health care and Dependent care expenses on a pre-tax basis. In addition, participation in the Cafeteria Plan portion of the Plan allows you to make contributions on a pre-tax basis (via paycheck withholding) to a Health Savings Account ("HSA") established and maintained outside of the Plan with your HSA trustee/custodian. (The Employer also may make contributions to your HSA.) The contributions withheld from your paychecks are excluded from your taxable income and, as a result, your taxable income is reduced.

This can be illustrated by the following example:

	With Pre-Tax Contributions	**Without Pre-Tax Contributions**
Gross Taxable Wages	$25,000	$25,000

Pre-tax Contribution	$1,800	N/A
Taxable Wages	$23,200	$25,000
Estimated Taxes*	$3,480	$3,750
After-tax Expenditure	N/A	$1,800
Take-home Pay	$19,720	$19,450

* Joint Return, 15% marginal tax rate

By paying for benefits before taxes are calculated, estimated taxes are reduced by $270, which is $22.50 per month more in take-home pay for the person in this example. In other words, paying for benefits without participating in the Plan costs this person $22.50 more per month.

Because participation in the Plan reduces your gross taxable income, it may affect your entitlement to Social Security benefits. In most instances, the benefit of the current tax savings (as illustrated above) will outweigh the slight (if any) impact on future Social Security benefits.

Please consult your tax advisor for a more accurate estimate for your personal situation.

6.1 Initial Election to Participate

Prior to meeting the eligibility requirements, you will be given an opportunity to complete an election to reduce your compensation. The election must be completed within 31 days from your date of initial eligibility. Your election will be effective beginning with the first day of the payroll period following the date you properly complete it, provided that the election is properly completed within 31 days from your date of initial eligibility.

6.2 When may I Change my Election?

You will be notified once each year, generally in October or November, of your right to change your election for the next calendar year by filing a new election. The election must be made no later than the deadline set forth in the open enrollment materials. If you do not properly complete a new election for each Plan Year, you will be treated as having elected to continue your Premium Payment Plan coverage election as in effect on the last day of the preceding Plan Year. However, if you do not complete a new election for a particular Plan Year, you will be treated as having elected to contribute nothing to the FSA Plan and Dependent Care Reimbursement Plan.

Additionally, if the cost of participation under the Employer's group health plan in which you participate increases or decreases with respect to the new year, and you are required to make a corresponding change in contribution, the Plan automatically will increase or decrease your corresponding contributions under the Premium Payment Plan.

Once an election is made, other than with regard to the HSA Plan, it cannot be changed by you during the Plan Year except under the following circumstances:

(a) HIPAA Special Enrollment: You may revoke an existing election and make a new election that corresponds with special enrollment rights under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

(b) Change in Status: If you have a change in status you may revoke or change a benefit election provided the election change is on account of and consistent with the change in status, and the change in status affects the eligibility of yourself, your Spouse or Dependent under an employer's cafeteria plan or other employee welfare benefit plan in which any of you are a participant. A change in status includes:

(1) your marriage, the death of your spouse, your divorce, legal separation or annulment;

(2) the death of your Dependent, or the birth, adoption or placement for adoption of your child, or an event that otherwise results in an increase or decrease in the number of your family members or Dependents who may benefit from coverage under the Plan;

(3) a change in employment status of you, your spouse, or your Dependent or yourself including the termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, a reduction or increase in hours of employment, including a switch from part-time to full-time employment status or vice versa, or a switch from hourly to salaried employment or vice versa;

(4) an event causing your Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, or any similar circumstance as provided in the plan under which you receive coverage;

(5) a change in the place of residence of yourself or your Spouse or Dependent; and

(6) such other events as the Plan Administrator determines qualify as a change in status, consistent with regulations and rulings of the Internal Revenue Service.

(c) Reduction of weekly hours of employment below 20: If your expected regular weekly hours of employment are reduced below 20, you generally will not be eligible for benefits and may be eligible for continuation coverage under COBRA.

(d) Enrollment in a Qualified Health Plan: You may revoke medical coverage under this Plan in order to enroll in a government-sponsored public "marketplace" plan of health coverage under certain circumstances.

(e) COBRA Eligibility: In the event you lose coverage under circumstances where you, your Spouse or your Dependent becomes eligible for continuation coverage

under your Employer's group medical, dental, or vision plan pursuant to federal law known as "COBRA," you may elect to continue those coverages by making a timely election. Because COBRA coverage generally costs more, you may elect to modify payments under the Plan as appropriate in order to pay for the continuation coverage.

(f) Court Order: Upon the entry of a judgment, decree or court order (including a qualified medical child support order under Section 609 of the Employee Retirement Income Security Act of 1974) resulting from a divorce, legal separation, annulment or change in legal custody requiring you or your former spouse to provide or cancel health coverage with respect to a child (cancellation to be permitted only if the order also requires another person to provide coverage for the child and such coverage actually is provided).

(g) Entitlement to Medicare/Medicaid: In the event you, your Spouse or your Dependent who is enrolled in the Employer's group health plan becomes entitled to or loses eligibility for coverage under Medicare or Medicaid, then you may cancel, reduce, add, or increase coverage for yourself, your Spouse or your Dependent accordingly.

(h) Significant change in Cost or Coverage (not applicable to the FSA Plan election): You may revoke an election and file a new election for the balance of the Plan Year under the following circumstances:

(1) if the cost to you (if any) for a benefit package option (e.g., a welfare benefit offered through this Plan, or an option for coverage under an underlying health plan, such as an indemnity option, an HMO option, or a PPO option) significantly increases or decreases (whether that increase or decrease results from an action taken by you or from an action taken by the Employer), or, with respect to the Dependent Care Reimbursement Account election, a significant cost change is imposed by a Dependent care provider who is not your relative, you may make a corresponding election change for the balance of the Plan Year;

(2) if coverage under one of the Employer's welfare plans (e.g., life, medical, or dental coverage) or a welfare plan of your Spouse or Dependent, is significantly curtailed or ceases (for example, there is a significant increase in the deductible, copay or out-of-pocket cost sharing limit under a health plan) during such Plan Year, but there is not a loss of coverage as defined in (c) below, you may revoke your election for that coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option providing similar coverage, provided such changes are permitted under the terms of the applicable welfare benefit plan;

(3) if you or your Spouse or Dependent has a significant curtailment of coverage that is a loss of coverage (that is, a complete loss of coverage

under the benefit package option or other coverage option (including the elimination of a benefits package option, an HMO ceasing to be available in the area where you reside, or your losing all coverage under the option by reason of an overall lifetime or annual limitation)), you may revoke your election under the Plan and, in lieu thereof, elect either to receive on a prospective basis coverage under another benefit package option providing similar coverage or to drop coverage if no similar benefit package option is available, provided such changes are permitted under the terms of the applicable welfare benefit plan;

(4) if a new benefit package option or other coverage option is added or if coverage under an existing benefit package option or other coverage option is significantly improved, you may revoke your election, and, in lieu thereof, make an election on a prospective basis for coverage under the new or improved benefit package option, provided such changes are permitted under the terms of the applicable welfare benefit plan; or

(5) you may make an election change on account of and corresponding with a change made under the plan of your spouse's, former Spouse's or Dependent's employer provided the election under your Spouse's or Dependent's plan satisfies both that plan's election change rules and IRS regulations regarding election changes, or your Spouse's or Dependent's plan has a different period of coverage.

(i) FMLA: In the event that you take a paid leave of absence under the Family Medical Leave Act ("FMLA"), your elections under the Plan with respect to the Premium Payment Plan and the FSA Plan will remain the same, and you will continue to make contributions in the same way that you made them prior to taking the leave of absence. You may make an election change with respect to a Dependent Care Reimbursement Account, provided the change is on account of and consistent with the leave. You will not be entitled to reimbursement of Dependent Care claims incurred during an FMLA leave.

If you take an unpaid leave of absence under the FMLA, you may revoke an existing election or continue health coverage (such as medical or dental coverage) under the Employer's health plans or coverage under the FSA Plan.

If you elect to continue coverage, to the extent that you are obligated to cover any premiums due during that time, you have two payment options: (i) pre-pay or (ii) pay-as-you-go. Under the pre-pay option, you may pay the premiums and contributions due during the FMLA leave period on a pre-tax salary reduction basis from any taxable compensation or on an after-tax basis prior to commencement of the leave. (Certain restrictions apply, however, if your FMLA leave spans two Plan Years.) Under the pay-as-you-go option, you may pay your share of premium payments and contributions on a monthly basis on the first of every month. These payments typically would be made on an after-tax basis, unless you receive taxable compensation during the leave period (e.g., as a result

of unused sick days or vacation days). The Employer may cancel your coverage retroactive to the beginning of the period for which a payment was due if you fail to make any payment before the end of the 30-day grace period for payments, provided if you are on an FMLA leave, the Employer notifies you of the overdue payment at least 15 days before the end of such grace period. Alternatively, the Employer, at its option, may continue your coverage during the leave and then recoup your share of premiums and contributions from available taxable compensation upon your return from leave.

If you do not elect to continue coverage while on FMLA leave, you are entitled to reinstatement upon your return to employment on the same terms as prior to taking FMLA leave, subject to any changes in benefit levels that may have taken place during the leave.

Upon reinstatement in the FSA Plan, you may resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or you may resume coverage at a level that is reduced and resume premium payments at the level in effect before the FMLA leave. If you do not elect to continue coverage during the FMLA leave under the FSA Plan while on FMLA leave, you will not be entitled to reimbursement for claims incurred during the FMLA leave.

Any election change (other than those made in connection with a court order or as an exercise of rights pursuant to a statute that provides for a specific election period such as HIPAA or COBRA) must be requested in writing within 31 days from the date of the change event. Any new election shall be effective not earlier than the first day of the next pay period beginning after receipt of the request by the Plan Administrator. You may not make an election change that would reduce your FSA Plan coverage to an amount that would be less than the amount of benefits claimed under such coverage as of the date the change would become effective.

An election to make a contribution to a HSA can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective as soon as practicable following the date that the election change was filed. No other Plan election changes can occur as a result of a change in your HSA Plan election, except as otherwise described above. For example, you generally would not be able to terminate an election under the FSA Plan in order to be eligible for a HSA Plan benefit, unless one of the exceptions described above with respect to FSA Plan otherwise applied.

VII. ELECTION CHANGES IMPOSED BY THE PLAN

Although it is unlikely that your elections and benefits under the Plan will be affected by the numerous discrimination tests that apply to them under the Internal Revenue Code of 1986, as amended (the "Code"), you should know that there are a number of legal limitations that apply to the Plan. The Plan Administrator reserves the right to modify any benefit elections by the amount necessary to allow the Plan to satisfy any applicable nondiscrimination requirements. If these discrimination tests ever apply to you, the Plan Administrator will inform you of the effect on your Plan elections and benefits. The nondiscrimination tests are to make sure the Plan does not operate to favor the highest paid employees.

Additionally, if the cost of participation in one of the Employer's insurance plans increases or decreases during a period of coverage, and, under the terms of the respective plan, you are required to make a corresponding change in payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in your elective contributions to the Plan.

VIII. WHAT BENEFITS ARE AVAILABLE UNDER THE PLAN?

8.1 Welfare Benefit Programs

The Welfare Benefit Programs under this Plan are provided as described in the Plan document, this document, and the applicable Benefit Descriptions for each particular Welfare Benefit Description as listed in Attachment A.

8.2 Pre-Tax Premium Account

You may elect to pay your share (if any) of the cost for coverage under any of the Employer's Welfare Benefit Programs for which you are eligible with pre-tax dollars. If you do not complete and return a new election form each Plan Year, you will be treated as having elected to continue your coverage option as in effect on the last day of the preceding Plan Year.

Current copies of the Benefit Descriptions either already have been or will be provided to you. If you misplaced your copy of any Benefit Description, you may contact the Plan Administrator to have them replaced or visit keheinsider.com to download an additional copy.

8.3 FSA PLAN

You may elect to put up to $2,650 in 2018 (as adjusted by the Employer from time to time) of your compensation per year into a General Purpose FSA Plan (the "General Purpose FSA") or a Limited Purpose FSA Plan to pay with pre-tax dollars unreimbursed medical expenses incurred with respect to yourself, your spouse, or any eligible individual who meets the definition of a "dependent" for this purpose under the Code (your "Dependent"). You cannot elect to contribute to both an HSA Plan and an FSA Plan, unless you elect the Limited Purpose FSA Plan option. In addition, if you carry a balance over from one Plan Year to the next under the General Purpose FSA, you cannot elect HSA benefits while the carryover amounts are available to you. For this purpose, your FSA Plan account balance is determined on a cash basis – that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

For purposes of the General Purpose FSA, eligible expenses are all of those permitted by Section 213(d) of the Code and include out-of-pocket medical, dental and vision expenses incurred by you, your spouse and your Dependents. Examples of eligible expenses are set forth below:

- Deductibles and co-payments under the Employer's health plans (including dental and vision plans) or under personal accident and health insurance carried by you, your Spouse, or covered Dependents;

- Prescription drugs;

- Over-the-counter drugs and products such as antacids, allergy medicines, pain relievers and cold medicines if you have a prescription, except that no prescription is needed for over-the-counter insulin;

- Over-the-counter medical devices and supplies;

- Eye care, including vision checkups, eyeglasses and contact lenses;

- Hearing care, including hearing examinations and hearing aids;

- Routine physical examinations;

- Any other medical care item that constitutes medical care within the meaning of Code Section 213(d).

Also, advance payment for covered orthodontia services and durable medical equipment may be reimbursed from the General Purpose FSA before such services are actually received. There is no reimbursement for the cost (e.g. premiums) of other health care coverage maintained outside of the Plan.

For purposes of a Limited Purpose FSA, eligible expenses shall only include vision care, dental care, or preventive care (as defined in Section 223(c) of the Code) or those medical expenses incurred after the deductible under your High Deductible Health Plan has been satisfied. This may include any prescription or over-the-counter drugs (if prescribed) to the extent that such drugs are taken by an eligible individual (1) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the eligible individual is asymptomatic); (2) to prevent the recurrence of a condition from which the eligible individual has recovered; or (3) as part of a preventive care treatment program (e.g., a smoking cessation or weight-loss program). Preventive care does not include services or treatments regarding an existing condition. In order to be reimbursed for an eligible health care expense, you must submit to the Plan Administrator a completed claim form and itemized bill from the service provider. In addition, no medical expenses incurred before you satisfy the deductible may be reimbursed except for vision, dental or preventive care, regardless of whether the High Deductible Health Plan covers the expense or whether the deductible later is satisfied.

Subject to the active military duty exception described below, if you do not use the entire amount you have elected to put into the account during the Plan Year for unreimbursed health care expenses incurred during the Plan Year, you will lose the unused balance to the extent that it exceeds $500. In other words, if there are any unused amounts remaining in your account at the end of a Plan Year, up to $500 may be carried over into the following Plan Year. It is therefore very important to estimate conservatively the amount of your prospective unreimbursed medical expenses for the Plan Year before electing the amount to contribute since your election cannot be changed except under certain narrow circumstances.

If you are a reservist called to active duty for a period of at least 180 days or for an indefinite period, the Plan may distribute to you all or a portion of the balance in your General FSA or Limited Purpose FSA account. The balance available for such a distribution will be the amount

contributed to the FSA Plan as of the date of the qualified reservist distribution request minus FSA Plan reimbursements received as of the date of the qualified reservist distribution request. In order to receive this money, you must request it on or after the date of the order or call to active duty, and before the last day of the Plan Year during which the order or call to active duty occurred. Before the Plan issues such a distribution, you must provide the Employer with a copy of the order or call to active duty. Distributions will be made no later than 60 days after the date of the request.

8.4 DEPENDENT CARE REIMBURSEMENT ACCOUNT

You may elect to put up to $5,000 of your compensation per year, if you are single, into the Dependent Care Reimbursement Account in order to pay with pre-tax dollars for child care expenses and other Dependent care costs to enable you to work. If you are married, filing a joint federal income tax return with your spouse, you and your spouse may together put up to $5,000 per year (but no more than the lower of your two incomes, except that if your spouse is a full-time student or is disabled she is considered to have a monthly income of $200 for one Dependent or $400 for two Dependents) into the Dependent Care Reimbursement Account. If you are married, filing separately, your limit is $2,500. If you are married and your spouse does not work (and she is not a full-time student or disabled), then you may not participate. The limits above apply to the total amount of Dependent care assistance you may receive during the Plan Year. Therefore, if you receive any such benefits under a plan of your spouse's company, these amounts must be offset against the amount you may contribute to this Plan. If you do not use the entire amount you have elected to put into the account for the Plan Year for Dependent care expenses incurred during either the Plan Year or its related "Run-Out Period" (as explained below), you will lose the unused balance.

The eligible expenses that may be reimbursed are those incurred for eligible Dependents in certain qualifying Dependent care arrangements. Eligible Dependents include your children up to age 13 and your other Dependents (for federal tax purposes) who are physically or mentally unable to care for themselves and reside in your home at least 8 hours per day. Qualifying Dependent care arrangements include (i) a day care center, provided that if care is provided by the facility for more than six individuals, it must comply with applicable state and local laws; (ii) an educational institution for pre-school children (for older children, only expenses for non-school care are eligible for reimbursement); and (iii) care provided inside or outside your home by an individual who is not your child under age 19 or your Dependent (for federal tax purposes). In any event, the total amount of Dependent care expenses incurred in a calendar year for which a participant may be reimbursed on a tax-free basis shall not exceed the maximum dollar amount indicated above.

8.5 HEALTH SAVINGS ACCOUNT

An HSA is an account established under Section 223 of the Code. Such arrangements are individual trusts or custodial accounts, each separately established and maintained between you and a qualified trustee/custodian. If you are an "HSA-Eligible Individual," you may elect to make contributions to an HSA. An "HSA-Eligible Individual" means an individual (other than an individual who can be claimed as a tax dependent or who is entitled to Medicare) who has elected qualifying High Deductible Health Plan ("HDHP") coverage and who has not elected any

disqualifying non-HDHP coverage pursuant to Section 223(c) of the Code. A "High Deductible Health Plan" is a health plan that meets the statutory limits for annual deductibles and out-of-pocket expenses for individual coverage and for family coverage, as defined in Section 223(c)(2) of the Code. For 2018, the minimum annual deductible limit is $1,350 (single coverage) and $2,700 (family coverage) and the maximum out-of-pocket expense limit is $6,650 (single coverage) and $13,300 (family coverage) under an HDHP. "Disqualifying coverage" might include coverage under your spouse's medical insurance plan or a general purpose health care flexible spending account offered under your spouse's cafeteria plan or this Plan.

You may not elect HSA Plan benefits if you also are contributing to the General Purpose FSA Plan. In addition, if you have an election for General Purpose FSA Plan benefits that is in effect on the last day of the Plan Year, you cannot elect HSA benefits for any of the first three calendar months following the close of that Plan Year, unless no amounts remain in your FSA Plan account at the end of that Plan Year.

Your annual contribution for HSA Plan benefits must not exceed the statutory maximum amount for the calendar year in which the contribution is made. For 2018, those maximum amounts are $3,450 for a person with single coverage under a high deductible health plan and $6,900 for a person with coverage for two or more persons under a high deductible health plan. Information as to the maximum contribution amounts in subsequent years will be provided by the Employer. An additional catch-up contribution ($1,000 in 2018) may be made if you are age 55 or older.

In addition, the maximum annual contribution shall be:

(a) reduced by Employer contributions (if any) made on your behalf to the HSA; and

(b) prorated for the number of months in which you are an HSA-Eligible Individual.

The Employer may limit the number of HSA providers to whom it will forward contributions, a list of whom (if any) will be provided upon request. Any such list of HSA trustees/custodians, however, shall be maintained for administrative simplification and shall not be an endorsement of any particular HSA trustee/custodian. The Employer has no authority or control over the funds deposited in your HSA. The Plan Administrator will maintain records to keep track of HSA contributions that you make through pre-tax payroll deductions, but it will not create a separate fund or otherwise segregate assets for this purpose. You must provide sufficient identifying information about your HSA to facilitate the forwarding of your pre-tax contributions to your designated HSA trustee/custodian.

IX. WHAT HAPPENS IF I DON'T USE UP ALL OF THE ELECTED BENEFITS DURING THE PLAN YEAR?

If you do not use the entire amount that you have put into the account during a particular Plan Year, you may carry over only up to $500 into the following Plan Year with respect to the FSA Plan, but you will lose any remaining amounts under the Dependent Care Reimbursement Plan. The remaining balance in the FSA Plan account in excess of $500 will be forfeited. Following the end of the Plan Year, you have 60 days in which to submit claims for reimbursement for expenses incurred during the Plan Year. This is called the "Run-out Period."

For example, assume that $600 remains in your FSA Plan account at the end of the 2018 Plan Year (after all claims for 2018 expenses have been submitted during the Run-Out Period and processed) and that you have elected $2,400 of FSA Plan coverage for 2019. Because the carryover is limited to $500, you will lose $100 from your account at the end of the 2018 Plan Year, and the remaining $500 will carry over for use during the 2019 Plan Year. This means that you will have a total of $2,900 (i.e., $2,400 election + $500 carryover) available in your FSA Plan account for 2019.

Eligible health care and Dependent care expenses incurred during a Plan Year and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. For example, assume that $200 remains in your FSA Plan account at the end of the 2018 Plan Year and that you also have elected $2,400 of FSA Plan account coverage for 2019. If you submit a $500 FSA Plan pending expense that was incurred on January 15, 2019, $200 of your claim will be paid out of the unused amounts remaining in your FSA Plan account from the 2018 Plan Year and the remaining $300 will be paid out of the amounts that are available to reimburse you from your FSA Plan account for the 2019 Plan Year.

X. WHAT HAPPENS IF I RECEIVE REIMBURSEMENTS TO WHICH I AM NOT ENTITLED UNDER THE PLAN?

If any over-payments are made to you under the Plan, you will be responsible for reimbursing the Plan for such amounts. Reimbursement may be made by any reasonable means available, including, but not limited to, offset against future benefits at the Plan's discretion, direct payment by you to the Employer or withholding from your future paychecks at the Employer's discretion. By participating in the Plan, you specifically authorize such withholding if needed to correct overpayments.

Moreover, if you deliberately defraud or mislead the Plan Administrator about the eligibility or entitlement to benefits of yourself or another person, the Plan Administrator has the right to terminate Plan coverage for you and/or any family members immediately and retroactively. The Plan shall be entitled to recover (as described above) from you and/or your family members any claims mistakenly paid due to mistake, fraud or a wrongful attempt to procure coverage, and to recover any costs and expenses arising from such fraud or misrepresentation, including, but not limited to, costs and expenses recoverable in actions at law and in equity. Additionally, fraud on your part shall be grounds for disciplinary action up to and including termination of employment.

XI. WHAT HAPPENS IF I TERMINATE EMPLOYMENT?

If you terminate employment, your pre-tax contributions to the Pre-Tax Premium Account, Dependent Care Reimbursement Account, and HSA Plan will cease. You may be entitled to continue your FSA Plan pursuant to the COBRA coverage continuation rules as described in the next section. If you incurred Dependent care expenses after you terminate employment or otherwise cease participation in the Plan, you may be reimbursed from the unused balance of your Dependent Care Reimbursement Account for expenses incurred during the Plan Year. However, you may not be reimbursed for amounts beyond your unused account balance, and you may not contribute additional amounts to the account.

If you terminate employment and are rehired during the same Plan Year, your election in the Plan automatically will be reinstated for the remainder of the Plan Year. However, if you are rehired more than 30 days after your termination, you will be eligible to make new elections for the remainder of the Plan Year. Regardless of when you are rehired, you may make a new election with respect to your HSA Plan benefit, so long as you are an HSA-Eligible Individual.

XII. COVERAGE DURING A LEAVE OF ABSENCE

FMLA Leave

If you take a leave of absence under the Family and Medical Leave Act of 1993, as amended ("FMLA"), you will be permitted to continue those Welfare Benefit Programs that provide group health benefits (i.e., group medical, dental and vision benefits, as well as employee assistance program benefits) on the same basis as an active Employee. You also will be permitted to continue those Welfare Benefit Programs that do not provide group health benefits according to the Employer's general policy of continuing all benefits during FMLA leaves of absence.

If you elect to continue coverage while on paid FMLA leave, your share of the premium must be paid through payroll deductions.

If you elect to continue coverage while on an unpaid FMLA leave, or your compensation is insufficient to pay your share of the premium during your paid FMLA leave, then you may pay your premium in one of the following ways:

(a) with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer; or

(b) through the cafeteria plan with pre-tax dollars upon returning from FMLA leave, by specifically electing to do so prior to taking such leave.

The Employer's obligation to maintain group health benefits provided under FMLA ceases if and when you inform the Employer of your intention not to return to work at the end of the leave or at the expiration of the leave.

The Employer's obligation also ceases if your premium payment is more than 30 days late. It is the Employer's policy in cases of FMLA and non-FMLA leaves of absence to cancel such coverage retroactively to the date when the premium payment was due if the premium is not

received within the 30-day grace period. The Employer may recover any unpaid portion of your premiums for any period during which coverage is continued upon your return to work.

If you fail to return to work at the end of an unpaid FMLA leave, the Employer may recover its share of group health plan premiums from you unless you do not return to work due to (i) the continuation, recurrence, or onset of a serious health condition of yourself or a family member which otherwise would entitle you to leave under the FMLA, or (ii) other circumstances beyond your control. Also, if the Employer maintains other benefits during an unpaid FMLA leave by paying both your share and the Employer's share of the premiums, the Employer will be entitled to recover the costs incurred for paying your share of any premiums whether or not you return to work.

Military Leave

Any Employee on a leave of absence due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"), may elect to continue medical, dental, vision, employee assistance program, HSA Plan, and FSA Plan coverage for 24 months for himself and his Dependents.

In order to continue receiving coverage, you must notify the Employer of your desire to continue receiving benefits within 60 days of providing notice to the Employer of your military leave. You will continue to be responsible for premium payments in the amount you were paying prior to the leave for the first 31 days of uniformed service, and the Employer will continue to make its predetermined contributions. If, after 31 days, you are still on leave for duty in the uniformed services, and elect to continue participation in the Plan, you will be responsible for 102% of the "full premium" for the coverage elected under the Plan until a total of 24 months have elapsed. The "full premium" shall be determined in the same manner as the "applicable premium" is determined under COBRA. Coverage continued under this provision runs concurrently with any continued coverage provided under COBRA.

Any Participant whose coverage under the Plan ended due to a period of the Employee's absence for duty in the uniformed services shall again become covered by the Plan without imposition of a new waiting period as soon as the Employee returns to employment as an Eligible Employee, provided that the Employee returns to, or reapplies for, reemployment within the period of time permitted under USERRA.

Other Leaves of Absence

If you are a salaried Employee and out on an approved disability or personal leave of any kind (even if you do not qualify for FMLA leave), all benefits under this Plan will continue for the duration of your leave. If you are an hourly Employee out on an approved disability leave of any kind and do not qualify for FMLA leave, benefits may or may not be continued according to local policies on a location-by-location basis. If you are subject to a CBA, that CBA may affect the benefits available and their duration during such leaves.

XIII. CONTINUATION COVERAGE UNDER COBRA

Continuation of medical, dental, vision, General Purpose FSA, employee assistance program, or other group health benefits may be available under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") to those Participants who experience a "qualifying event." COBRA is not available with respect to any other benefits. In addition to the following information, further information pertaining to your rights afforded under COBRA is provided in detail in the applicable Benefits Descriptions, as well as in the Employer's COBRA notices. You also may obtain information from the COBRA Administrator identified earlier under "Important Contact Information."

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health coverage under the Plan when coverage would otherwise end because of a "qualifying event." Specific qualifying events are listed later in this Section. After a qualifying event occurs and any required notice of that event is properly provided to the COBRA Administrator, COBRA continuation coverage must be offered to each person losing coverage who is a "qualified beneficiary." You and your Dependents could become qualified beneficiaries and be entitled to elect COBRA if coverage under the Plan is lost because of a qualifying event.

COBRA continuation coverage is the same coverage that the Plan gives to other similarly situated persons under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as other persons covered under the Plan.

Who Is Entitled to Elect COBRA?

Employees and Dependents will be entitled to elect COBRA if a loss of group health coverage under the Plan occurs because either one of the following qualifying events happens:

- Hours of employment are reduced;
- Employment ends for any reason other than gross misconduct;
- Employee dies;
- Divorce or legal separation; or
- Dependent child loses "Dependent" status under the Plan.

An Employee and/or his Dependents must have been both eligible for coverage and actually covered by the Plan on the day prior to the date of the qualifying event to receive COBRA continuation coverage.

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or the death of the Employee, the Employer must notify the COBRA Administrator of the qualifying event.

Employees and/or Dependents Must Give Notice of Some Qualifying Events

For certain qualifying events (including divorce, legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), the Employee or Dependent (or an authorized representative) must notify the COBRA Administrator in writing within 60 days after the later of (i) the date of the qualifying event, or (ii) the date on which the qualified beneficiary would lose coverage under the Plan as result of the qualifying event.

How Do You Elect and Enroll in COBRA Continuation Coverage?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees (and Spouses if the Spouse is a qualified beneficiary) may elect COBRA continuation coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA continuation coverage on behalf of their children. An Employee may not waive COBRA continuation coverage for his Spouse and vice versa.

Any qualified beneficiary for whom COBRA is not elected within the 60-day election period described in the Plan's COBRA Election Notice will lose his or her right to elect COBRA continuation coverage.

Special Second Election Period under the Trade Act

If an Employee qualifies for federal trade adjustment assistance (TAA) under the Trade Act of 2002, as amended, then the Employee and his or her qualified beneficiaries will be provided an additional 60-day enrollment period with continuation coverage beginning on the date of such TAA approval. Further information is available at http://webapps.dol.gov/elaws/ebsa/health/employer/C19.htm.

How Much Does COBRA Continuation Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated Plan participant or beneficiary who is not receiving COBRA continuation coverage.

When must payment for COBRA continuation coverage be made?

If you elect COBRA continuation coverage, you do not have to send any payment with your election. However, you must make your first payment for COBRA continuation coverage not later than 45 days after the date of your election. If you do not make your first payment for COBRA continuation coverage in full within 45 days of the date of your election, you will lose all continuation coverage rights under the Plan.

Your first premium payment must include payment for the period from the date that you lost (or otherwise would have lost) coverage until the date of your election, and each regularly scheduled monthly premium that became due during the period between your election and the first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment. Claims for reimbursement may not be processed and paid until you have elected COBRA and made the first payment.

After you make your first payment for COBRA continuation coverage, you will be required to make monthly payments for each subsequent month of coverage. Under the Plan, each of these monthly payments is due on the first of the month for that month's COBRA continuation coverage. If you make a monthly payment on or before the first day of the month to which it applies, your coverage under the Plan will continue for that coverage period without any break. If you do not make a monthly payment on or before the first day of the month, your coverage may be suspended pending payment. The Plan is not required to send monthly notices of payments due for these coverage periods. It is your responsibility to pay your COBRA premiums on time, regardless of whether you receive a monthly bill.

Although monthly payments are due on the first day of each month of COBRA continuation coverage, you will be given a grace period of 30 days to make each monthly payment. Your COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. If you fail to make a monthly payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

How Long Does COBRA Continuation Coverage Last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an Employee's death, divorce, legal separation, the Employee's becoming entitled to Medicare benefits or a Dependent child ceasing to be a Dependent under the terms of the plan, coverage may be continued for up to a total of 36 months.

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

- Any required premium is not paid in full on time,
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a pre-existing condition of the qualified beneficiary,
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- The Employer ceases to provide any group health plan.

Additionally, COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving continuation coverage (such as fraud).

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. Please notify the COBRA Administrator of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or a second qualifying event may affect the right to extend the period of continuation coverage.

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration ("SSA") to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Please notify the COBRA Administrator of the disability determination within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All qualified beneficiaries who have elected continuation of coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the COBRA Administrator of that fact within 30 days of SSA's determination. Where a disability event occurs, please locate the required form and instruction for providing notice to the COBRA Administrator.

An 18-month extension of coverage will be available to Spouses and Dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee becoming entitled to Medicare benefits (under Part A, Part B, or both) or a Dependent child ceasing to be eligible for coverage as a Dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualifying beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the COBRA Administrator within 60 days after a second qualifying event occurs or within 60 days of your loss of coverage under the Plan as required under the terms of the Plan.

If You Have Questions

Questions concerning COBRA continuation coverage rights under the Plan should be addressed to the COBRA Administrator or the Plan Administrator.

XIV. AMENDMENT AND TERMINATION OF THE PLAN

The Plan Sponsor reserves the right to amend or modify the Plan in writing at any time and for any reason. The amendment is effective only when approved by the body or person to whom such authority is formally granted by the terms of the Plan. Oral changes to the Plan are not permitted.

It is the intention of the Plan Sponsor to continue the Plan indefinitely. However, the Plan Sponsor reserves the right to terminate the Plan and each Adopting Employer reserves the right to terminate its participation in the Plan at any time, either in whole or in part. In the event of termination of the Plan, any remaining assets of the Plan shall be used to provide benefits under the Plan or to pay administrative expenses or be retained by the Plan Sponsor, subject to applicable law.

In the event the Plan or a Welfare Benefit Program provided under the Plan is terminated, payment of claims under the Plan shall be limited to those claims incurred as of the date the Plan or Welfare Benefit Program is terminated. The Employer will not have any liability for any covered charges incurred after the effective date of termination of the Plan or Welfare Benefit Program.

XV. CLAIMS PROCEDURES

Claims for benefits under the Plan are administered by the applicable Claims Administrator. Your claims for such benefits will be decided in accordance with the reasonable claims procedures contained in the applicable Benefit Descriptions, as required by ERISA (to the extent applicable to a particular Welfare Benefit Program) and other applicable law. If your claim is denied (that is, not paid in part or in full), you will be notified and you may appeal to the applicable Claims Administrator for a review of the denied claim. If you do not appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a condition for bringing suit in court). The applicable Claims Administrator will decide your appeal in accordance with its claims procedures. Under certain circumstances, you may have the right to obtain external review of your appeal (that is, review outside of the Plan). You will lose your right to sue under ERISA if you do not file any such action within one year of when your claim rights first expire or are exhausted.

You should refer to the Benefit Description of the respective Welfare Benefit Program for a description of the applicable claims procedures. Contact the applicable Claims Administrator for additional claims information and for any forms that may be available to submit any claims or appeals. In the event that the claims procedures set forth in the applicable Benefit Description are inadequate to comply with ERISA, the claims procedures set forth in Appendix B will apply.

NOTE: The procedures set forth in Appendix B only apply if the particular Welfare Benefit Program does not provide for a claims appeal procedure that satisfies the requirements of ERISA. You should contact the Claims Administrator and the Plan Administrator before instigating an appeal under these procedures.

XVI. COORDINATION OF BENEFITS

Health benefits (e.g., medical, dental and vision benefits) will be coordinated in accordance with the applicable coordination of benefits provisions set forth in the Benefit Descriptions for the applicable Welfare Benefit Program. If there are no such provisions, then the following provisions will apply:

(a) Maximum Benefits. If a Participant covered under the Plan, is also covered under one or more other plans and the sum of the benefits payable under all the plans exceeds the Participant's Eligible Charges during a Plan Year, then the benefits payable under all the plans involved shall not exceed the Eligible Charges for that period as determined under this Plan. Benefits payable under another plan are included whether or not a claim has been made.

(b) For purposes of this Section, "Eligible Charge" means any necessary, reasonable, and customary item of which at least a portion is covered under this Plan, but does not include charges specifically excluded from benefits under the Plan that also may be eligible under any other plans covering the Participant.

For purposes of this Section, "Other Plan" means the following plans providing benefits or services for medical, dental, or vision treatment:

(1) group insurance or any other arrangement for coverage for individuals in a group, whether on an insured or self-insured basis; or

(2) any other prepayment coverage, including health maintenance organizations ("HMOs"), Medicare, or Medicaid.

(c) Order of Payment. If a Participant is covered under two or more plans, the order in which benefits shall be determined is as follows:

(1) The plan covering the individual as an employee pays benefits first. The plan covering the individual as a dependent pays benefits second.

(2) If no plan is determined to have primary benefit payment responsibility under (1) of this subsection, then the plan that has covered the individual for a longer period of time has the primary responsibility.

(3) A plan that has no coordination of benefits provision will be deemed to have primary benefit payment responsibility.

(4) If a dependent child is covered under the plans of both parents and the parents are married, then the plan of that parent whose birthday falls earlier in the calendar year will pay before the plan of the parent whose birthday falls later in the calendar year.

(5) In the event that the parents of an eligible dependent are divorced or legally separated, the following order of benefit determination applies:

(i) The plan covering the parent with custody pays benefits

first.

(ii) If the parent with custody has not remarried, then the plan covering the parent without custody pays benefits second.

(iii) If the parent with custody has remarried, then the plan covering the step-parent pays benefits second and the Plan covering the parent without custody pays benefits third.

(iv) However, if a divorce decree or other order of a court of competent jurisdiction such as a qualified medical child support order places the financial responsibility for the child's health care expenses on one of the parents, then the plan covering that parent pays benefits first.

(6) The plan covering an individual as an active employee (or as the employee's dependent) pays benefits first. The plan covering that individual as a laid-off or retired employee (or that employee's dependent) pays benefits second.

(7) The plan covering an individual as an active employee, or as a dependent of the employee, pays benefits first if such an individual is also being provided COBRA coverage under another plan, and such Other Plan pays benefits second for such an individual. Conversely, this Plan pays secondary benefits for any individual who is provided COBRA coverage under this Plan and who also is covered simultaneously under another plan as an employee, or dependent of an employee.

(8) In the event of conflicting coordination provisions between this Plan and any Other Plan, this Plan will pay primary benefits for an individual only if this Plan has provided coverage for a longer period of time.

(d) Facilitation of coordination. For purposes of coordination of benefits, the Plan Administrator:

(1) may release to, or obtain from, any Other Plan (including such Other Plan's insurance provider or third party administrator, or other organization or individual performing functions on behalf of such Other Plan), any claim information and any individual claiming benefits under the Plan must furnish any information that the Plan Administrator may require;

(2) may recover on behalf of the Plan any benefit overpayment from any Other Plan, and

(3) has the right to pay to any Other Plan an amount it shall determine to be warranted, if payments that should have been made by the Plan have been made by such Other Plan.

(e) Medicare coverage. The Plan shall be considered the primary payer, and Medicare the secondary payer, for those services, treatments, and supplies that would otherwise have been provided by Medicare in the case of:

(1) any Participant, or Participant's Spouse who is also entitled to Medicare benefits for as long as such Participant remains an Employee of the Employer;

(2) any disabled Participant, or Dependent who is entitled to Medicare but still participates in the Plan; and

(3) any Participant, or Dependent who is entitled to Medicare benefits solely on the basis of having end-stage renal disease ("ESRD"), provided that Medicare shall be considered to be the primary payer of benefits on behalf of an insured individual with ESRD after expiration of the period that begins on the date the Participant first becomes entitled to Medicare part A benefits under the Social Security Act and ends 18 months later.

(f) Benefits covered by Medicaid. The Plan shall not reduce or deny benefits for any Participant or Dependent to reflect the fact that such an individual is eligible to receive medical assistance under a state Medicaid plan.

(g) The Plan shall provide benefits for any active Employee age 65 or older or any Dependent age 65 or older under the same terms and conditions that apply to an active Employee who is under age 65 or a Dependent under age 65.

XVII. MISCELLANEOUS LEGAL PROVISIONS

Right to Examination

To the extent permitted by law, the Claims Administrator or the Plan Administrator shall have the right to require you to submit to a medical examination, at the Plan's expense, when and so often as may be reasonably necessary while a claim is pending.

Nonalienation of Benefit

The right of any Employee or his Dependent to receive Plan benefits shall not be subject to alienation, assignment or transfer, voluntarily or involuntarily, by operation of law or otherwise, and you may not assign, transfer or dispose of such right nor shall any such right be subjected to attachment, garnishment, or other legal, equitable or other process. However, you may direct that benefit payments due to you be paid to any hospital or medical service provider in consideration of medical or hospital services given or supplies furnished or to be furnished.

Right to Recover Excess Benefit Payments

The Plan shall be entitled to recover (by means of offset against future benefits or any other means of recovery) from you and/or your Dependents any excess payments paid to you or your Dependents, (or on your/their behalf) due to mistake, fraud or any other reason. The right of recovery and offset shall not limit the rights of the Plan to recover overpayment in any other manner.

Choice of Law/Venue

This Plan shall be interpreted according to the laws of the state of Illinois, and any lawsuit involving Plan benefits or fiduciaries must be filed in the United States District Court for the Northern District of Illinois, or if no federal jurisdiction exists, in the state court having jurisdiction over matters arising in Chicago, Illinois.

No Employment Rights

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Employer to the effect that you will be employed for any specific period of time.

Limitation of Rights and Liability

The Plan will not be construed as giving to any Participant or other person any legal or equitable right against the Plan Administrator or the Employer beyond those rights expressly set forth in the Plan. Nothing in the Plan shall be construed to require the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant in the Plan, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made. With respect to any insured Welfare Benefit Program, liability for providing benefits under such Welfare Benefit Program shall be solely that of the insurance company (including but not limited to a health maintenance organization) issuing the policy for the applicable insured Welfare Benefit Program. The Employer shall have no liability for any benefits due, or alleged to be due, under any such insured Welfare Benefit Program.

Nonvested Benefits

Participants do not have a vested right to any benefits under the Plan.

Rebates

If the Employer receives any rebates from an Insurer under a group insurance contract as a result of the Insurer's contracted medical loss ratio, the Employer may distribute such rebates in a manner to reduce Plan costs or as a refund to Participants.

Qualified Medical Child Support Orders

This Plan recognizes qualified medical child support orders ("QMCSOs") and provides benefits for a dependent child as determined by a court order in the event of a divorce or other family law action. Orders must be submitted to the Plan Administrator who will determine whether the order is a QMCSO, as required under federal law. Contact the Plan Administrator for more information regarding QMCSOs or a free copy of the QMCSO procedures.

Mental or Physical Incapacity

If an Employee or his Dependent is determined to have incurred a mental or physical incapacity, payments under the Plan may become due and made to another person appointed to be a guardian of such Employee or Dependent. If no such guardian has been appointed, the Plan shall wait until such guardian is appointed before making such a payment. An Employee or his Dependent will be deemed to be mentally or physically incapacitated when the Employee or Dependent has a physical or mental defect, illness, or impairment, supported by competent medical testimony, of such a debilitating nature as to reduce substantially or eliminate the Employee's or his Dependent's ability to attend to his business affairs.

Subrogation and Right of Reimbursement

The following subrogation and reimbursement rights provisions will apply self-insured Welfare Benefit Programs, and to the extent that an applicable Benefit Description does not address subrogation and reimbursement rights of the Employer or insurer.

(a) General Subrogation

(1) By accepting benefits under the Plan, Participants and their Dependents agree to be subject to the terms and conditions of these Subrogation and Right of Reimbursement provisions of the Plan. It is the intent of the Employer and the Plan that no individual shall receive any profit or be unjustly enriched from the payment of insurance or other benefits from the Plan, or from the payment of any Compensation for injuries. Therefore, expenses that are caused by, contributed to, or the responsibility of any Third Party or that are work-related are not covered expenses under the terms of the Plan to the extent that any amounts are recovered by a Claimant from a Third Party related to such Third Party Incident, regardless of how the recovered amounts are characterized.

To the extent of any payments the Plan makes or may be obligated to make for a claim related to a Third Party Incident, the Plan shall be subrogated to any and all rights of recovery and causes of action that the Claimant may have against any and all parties responsible for causing the injuries or illness relating to the Third Party Incident. Further, upon settlement or adjudication of any claim arising out of the Third Party Incident, the Claimant shall reimburse the Plan in full for any benefits advanced by the Plan related to the Third Party incident, regardless of how the settlement

or award is characterized. The Plan Administrator may require the execution of a Subrogation and Reimbursement agreement, in a form to be provided by the Plan Administrator, but the Plan's rights to Subrogation and Reimbursement apply regardless of whether the Claimant executes a Subrogation and Reimbursement agreement.

If Claimant obtains a recovery with respect to the Third Party Incident, no further benefits will be payable from the Plan for any claims related to the Third Party Incident, until the total covered expenses arising out of the Third Party Incident equals the gross amount of the recovery paid to or on behalf of the Claimant. The Plan then will consider only the amount of claims that exceeds the amount of the gross recovery. However, the Plan in its discretion may choose to advance amounts as payment for expenses for medical care in situations where or at a point in time when liability for such expenses has not been established, on the condition that the advance is reimbursed in full upon the settlement or adjudication of the Third Party claim. No loan transaction is created by this advance.

(2) Definitions.

A "Claimant" is the Employee or Dependent, and includes representatives, guardians, trustees, estate representatives, heirs, executors, administrators of special needs trusts and any other agents, persons or entities that may receive a benefit on behalf of or for Claimant.

A "Third Party Incident," for purposes of this Section, is any instance in which a third party (defined below) causes injuries or illness and/or otherwise is or may be responsible or liable for paying all or part of the expenses for which a claim is filed with the Plan, or any injury that is work-related.

A "Third Party" for purposes of this Section could be, but is not limited to:

- A third party tortfeasor (an individual or other entity of any kind who caused harm, such as the driver of another car in an automobile accident);
- An employee welfare plan or arrangement;
- A medical or hospital benefit plan;
- A no-fault or other car insurance policy;

- An uninsured or underinsured motorist provision or medical pay provision of a car insurance policy;
- A homeowners, school or athletic insurance policy;
- An employer or workers' compensation insurance carrier;
- A liability insurance policy of any kind or nature; or
- Any other third party which is obligated to make payments which the Plan would otherwise be obligated to make.

"Subrogation" refers to the Plan's right to recover for benefits paid and advanced by the Plan on a claim if a Third Party is responsible for paying the expenses for which the claim is made, by transferring the Claimant's right to recover those benefits from a Third Party, which may include pursuing a cause of action against a Third Party for benefits advanced on behalf of the Claimant, to the Plan. To the extent of any payments the Plan makes or may be obligated to make for a claim related to a Third-Party Incident, the Plan shall be subrogated to any and all rights of recovery and causes of action that the Claimant or a representative, guardian or custodian of the Claimant may have relating to the Third-Party Incident.

"Reimbursement" refers to the Plan's contractual right to be reimbursed from expenses advanced on a claim if a Third Party is responsible for paying the expenses for which the claim is made.

"Compensation" for injuries includes any judgment, award or any settlement, whether or not the terms of the judgment, award or settlement expressly include or exclude medical expenses and disability recovery. It is specifically intended to give the Plan the right to recover all benefits it paid on a claim, whether or not the Claimant has been made whole.

(b) Subrogation and Reimbursement

(1) Right to Subrogate. This Plan shall be fully subrogated to any and all rights of recovery and causes of action that the Claimant may have relating to the Third Party Incident. The Subrogation right applies on a priority, first dollar basis to any recovery, whether by suit, settlement or otherwise, whether a partial or full recovery and regardless of whether the Claimant is made whole, from any source liable for making a payment relating to the injury, illness or condition to which the claim relates. Thus, the Plan specifically rejects the "made whole doctrine" and any other equitable doctrine

or law that requires an insured to be "made whole" before subrogation rights are allowed. Furthermore, it is prohibited for a Claimant to settle a claim against a Third Party for certain elements of damages, but eliminating damages relating to medical expenses incurred.

To the extent of any payments the Plan advances for a claim related to a Third Party Incident, the Plan shall be subrogated to any and all rights of recovery and causes of action that the Claimant or a representative, guardian or custodian of the Claimant may have relating to the Third Party Incident. The Claimant agrees to cooperate fully with the Plan in the prosecution of any claims, causes of action or rights against any Third Party.

(2) Right to Reimbursement. The Claimant will first reimburse the Plan on a priority basis for all payments the Plan made or may be obligated to make for the claim from any recovery relating to a Third Party Incident, whether by suit, settlement or otherwise, including partial or full recoveries and regardless of whether the Claimant is made whole. Once the Plan makes or is obligated to make payments for benefits on behalf of any Claimant, the Plan is granted, and the Claimant consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the Claimant from any Third Party. Notice of a lien is sufficient to establish the Plan's lien against the Third Party.

Claimant will take such action as necessary or appropriate to recover any and all payments made or to be made by the Plan, regardless of whether or not the Claimant is made whole by any subsequent recovery. If the Third Party does not voluntarily pay Claimant for the incurred expenses and Claimant does not sue the Third Party for recovery of the expenses, the Plan has the right to sue the Third Party in Claimant's name to recover the amount it paid. In such a case, if there is a recovery or settlement, the Claimant further agrees that the Plan's expenses, costs and incurred attorney's fees will also be paid out of the recovery or settlement.

(3) Enforcement of Rights. The Plan has the right to recover amounts representing the Plan's Subrogation and Reimbursement interest through any appropriate legal or equitable remedy, including but not limited to the initiation of a recognized cause of action under ERISA or other applicable federal or state law, the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any Claimant for recovery from any third party,

whether by settlement, judgment or otherwise. The Plan may participate in any legal action Claimant or anyone acting on Claimant's behalf may file against the Third Party to recover the expenses. The Plan's Subrogation and reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity. The Claimant shall cooperate with the Plan and/or any and all representatives of the Plan, including subrogation counsel, in completing discovery, attending depositions, and/or attending or cooperating at a trial in order to effect the Plan's Subrogation and Reimbursement rights.

Further, where the Claimant or its agent receives a recovery from any third party but does not reimburse the Plan, the Plan shall have the right to offset the amount of future benefit payments on the claims submitted by the Claimant and the Participant (if different from the Claimant) covered under the terms of the Plan until the Plan has recovered the full amount allowed under this Section.

The Plan's right of Subrogation and Reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Claimant, whether under the doctrines of imperative causation, comparative fault or contributory negligence, or any other similar doctrine in law. Accordingly, any so called "lien reduction statutes," which attempt to apply such laws and reduce a subrogating Plan's recovery for any reason, including contributory negligence, will not be applicable to the Plan and will not reduce the Plan's Subrogation recovery. The benefits provided under this Plan are secondary to any benefits or coverage provided under any no-fault law or similar legislation or no-fault-type insurance.

The Plan is entitled to first-dollar recovery regardless of whether the settlement or award is characterized as amounts for medical expenses or as amounts other than for medical expenses. The Claimant waives and agrees to hire an attorney that waives any and all state law, statutory, or common law defenses to first-dollar recovery by the Plan, including but not limited to the make-whole rule, the Common Fund Doctrine, lien reduction statutes, and the collateral source rule.

(4) Coordination of Benefits. These Subrogation and Reimbursement rules do not apply to benefits Claimant recovers under another employer-sponsored group health plan if that coverage is subject to Coordination of Benefits rules described under the Plan.

(5) Subrogation and Reimbursement Agreement. The Plan is not and will not be liable for, nor does it or will it have any obligation to pay, any benefit arising out of a Third-Party Incident. If a claim is

submitted for expenses for which someone else is or may be legally responsible, the Claimant, or his or her agent, must execute a Subrogation and Reimbursement agreement and return it to the Plan Administrator as soon as possible. However, notwithstanding the preceding, as described initially in this Section above, simply by accepting benefits under the Plan, you and/or your Dependent agree to be subject to the terms and conditions of this Section. Failure to comply with this Section may result in offsets or other collective actions against the Employee and/or his Dependents. If Claimant is a minor or is otherwise legally incompetent, Claimant's parent, legal guardian or "next friend" must execute the Subrogation and Reimbursement agreement on his or her behalf.

The Subrogation and Reimbursement agreement will be binding upon the Claimant whether the payment received from the Third Party or its insurer results from a legal judgement, an arbitration award, a compromise settlement, or any other arrangement. The Subrogation and Reimbursement agreement also will be binding on any recovery made by the Claimant, even if the recovery does not include medical expenses.

(c) Miscellaneous Subrogation Rules

(1) Separate Rights. The Plan's right to Reimbursement and the Plan's right to Subrogation are separate and distinct rights and obligations. The failure or invalidity, in whole or in part, of one such right or obligation will not impair or otherwise adversely affect any such other right or obligation.

(2) Attorneys' Fees. The Plan specifically disavows any claim the Claimant and/or Claimant's attorney may make under the "Common Fund Doctrine." This means that the Plan shall not be responsible for any of the Claimant's court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses incurred in seeking a recovery, whether by suit, settlement or otherwise, unless the Employer had agreed in writing to pay such fees or costs.

The Claimant specifically is prohibited from incurring any expenses, costs, or fees on behalf of the Plan in pursuit of his rights of recovery against a Third Party or the Plan's Subrogation and Reimbursement rights as set forth herein.

Claimant agrees to indemnify the Plan for any cause of action brought by the Claimant's current or former attorney against the Fund seeking payment of fees or seeking to assert quantum meruit, the common fund doctrine, or any similar legal right or doctrine.

(3) Employer Right to Waive. The Employer may waive its Subrogation or Reimbursement rights, or any part thereof, if it decides such action is in the best interest of the Plan and its Participants.

(4) Anti-Assignment. By accepting benefits under the Plan, Claimants are prohibited from doing anything that will impair, release, discharge or prejudice the Plan's Subrogation or Reimbursement rights.

No Claimant may assign any rights or causes of action that he or she might have against a Third Party, which would grant the Claimant the right to recover medical expenses or other damages, without the express, prior written consent of the Plan. The Plan's Subrogation and Reimbursement rights apply even where a person has died as a result of his or her injuries and the Claimant is asserting a wrongful death or survivor claim against the Third Party under the laws of any state. The Plan's right to recover by Subrogation or Reimbursement shall thus apply to any settlements, recoveries, or causes of action owned or obtained by a decedent, minor, incompetent, or disabled person.

(5) Maximum Amount of Recovery. Neither Claimant nor any other person will be required to reimburse the Plan more than the benefits the Plan pays on the applicable claim, or more than the gross amount the Claimant receives in recovery, whichever is less, without regard to attorney's fees and expenses incurred in obtaining such recovery.

(6) Fiduciary Status. Should any money subject to the Subrogation and Reimbursement agreement or to this Section be recovered by or on behalf of any Claimant, and such money is transferred to the Claimant, Claimant agrees that such money is a Plan asset and that Claimant is a fiduciary to the Plan with respect to that money, pursuant to ERISA § 3(21)(A)(i). As a fiduciary, Claimant is required to hold the money in trust on behalf of the Plan and not otherwise spend or distribute the money until the Plan has released its Subrogation or Reimbursement lien in writing. If the Claimant is a fiduciary pursuant to the foregoing, a failure to comply with the Subrogation and Reimbursement agreement or the provisions of this Section shall be considered a breach of fiduciary duty, and the Plan may enforce the terms of the Subrogation and Reimbursement agreement or this Section through legal action, offset, or any other available legal or equitable means.

Important Notices of Specific Rights Under the Law.

(a) Newborns' and Mothers' Health Protection Act of 1996

The Plan does not restrict medical benefits for a hospital 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, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). The Plan does not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

(b) Women's Health and Cancer Rights Act of 1998 Notice

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan chooses to cover mastectomies, then the plan is generally subject to WHCRA requirements. To the extent WHCRA applies to a particular Welfare Benefit Program, coverage will be provided for: (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance and (3) prostheses and physical complications of mastectomy, including lymphedemas.

(c) Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 protects Americans against discrimination based on their genetic information when it comes to health insurance and employment. As a result, the Plan does not adjust premium or contribution amounts on the basis of genetic information, request or require individuals to undergo genetic testing, or request or require genetic information for underwriting purposes.

(d) Mental Health Parity Addiction and Equity Act of 2008

The Mental Health Parity Addiction and Equity Act of 2008 requires that the annual or lifetime dollar limits on mental health and substance abuse benefits may not be lower than any such dollar limits for health and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. Federal law also requires that plans providing both medical/surgical benefits and mental health/substance abuse benefits may not impose more restrictive financial requirements (such as deductibles and copayments) and treatment limitations (such as limits on days of coverage) on mental health benefits than are imposed on medical/surgical benefits.

(e) HIPAA Privacy Notice

You have been furnished under separate cover a Notice of Privacy Practices describing the practices the Plan will follow with respect to each Welfare Benefit Program, with regard to your "protected health information." If you need another copy, contact the Plan Administrator.

(f) Patient Protection Notice

The Plan does not require the designation of a primary care provider, except in the case of certain HMO coverage. However, using a primary care provider can improve your health care outcomes and save you money. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical Claims Administrator at the number on the back of your medical benefit ID card.

The Plan does not require you to obtain prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical Claims Administrator at the number on the back of your medical benefit ID card.

XVIII. ERISA RIGHTS

As a Participant in this Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to:

(a) Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

(b) Continue Group Health Plan Coverage

Continue health care coverage for yourself or your Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD, the applicable Benefit Descriptions and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You should be provided a certificate of creditable coverage, free of charge from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

(c) 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 plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the plan or exercising your rights under ERISA.

(d) Enforce Your Rights

If your claim for a welfare 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 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. In addition, if you disagree with the plan'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 the 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 if, for example, it finds your claim is frivolous.

(e) Assistance With Your Questions

If you have any questions about the 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.

XIX. GENERAL PLAN INFORMATION

Name of Plan: Evraz North America Employee Benefit Plan

Plan Sponsor: Evraz North America

	200 East Randolph, Suite 7800 Chicago, IL 60601 (312) 533-3555
Employer Identification Number:	96-0506370
Plan Administrator/Named Fiduciary:	Evraz North America 200 East Randolph, Suite 7800 Chicago, IL 60601 (312) 533-3538
Claims Administrators:	Medical Benefits: Highmark BCBS (866) 217-5067 Kaiser Permanente (800) 813-2000 Life, AD&D, and Long-Term Disability Benefits: Standard Insurance Company (800) 628-8600 Dental Benefits: Delta Dental – Moda Health (888) 217-2365 Vision Benefits: VSP (800) 877-7195 Short-Term Disability Benefits: Standard Insurance Company (800) 628-8600 Employee Assistance Program: Magellan EAP (800) 523-5668
COBRA Administrator:	BRI Administrators 3090 Fite Circle, Suite 201 Sacramento, CA 95827 (888) 902-6272
Plan Number:	501
Plan Year:	January 1 through December 31 each year.

Type of Plan:	A group health and welfare plan that provides medical, dental, vision, long-term disability, short-term disability, life, AD&D, employee assistance program, retiree health reimbursement, and cafeteria plan benefits, including and FSA Plan, Dependent Care Reimbursement Plan, and HSA Plan.
Agent for Service of Legal Process:	Evraz North America 200 East Randolph, Suite 7800 Chicago, IL 60601 (312) 533-3555

Appendix A

BENEFIT DESCRIPTIONS

Note: The following list of Benefit Descriptions may be updated from time to time. Contact the Plan Administrator if you have questions about the following documents.

Medical Benefits (as applicable):

- Booklet entitled "Large Group Traditional Plan Evidence of Coverage" from Kaiser Permanente
- Booklet entitled "Large Group Deductible Plan Evidence of Coverage" from Kaiser Permanente
- Booklet entitled "Evidence of Coverage – Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Kaiser Permanente Senior Advantage Group Plan (HMO)" from Kaiser Permanente

- Booklet entitled "Evraz High Deductible Health Plan" from Blue Cross Blue Shield

- Booklet entitled "Evraz Value Based Plan" from Blue Cross Blue Shield

- Booklet entitled "Evraz North America" from Blue Cross Blue Shield

Dental Benefits:

- Booklet entitled "Dental Only Plan" from Delta Dental
- Booklet entitled "Large Group Dental Plan Evidence of Coverage" from Kaiser Permanente

Vision Benefits:

- Booklet entitled "Group Vision Care Plan Administrative Services Program" from VSP

FSA Plan:

- Booklet entitled "Flexible Benefit Plan (including Limited Medical Flexible Spending Account and HSA) with Beniversal® MasterCard® Prepaid Card Summary Plan Description" from Beniversal

Dependent Care Reimbursement Plan:

- Booklet entitled "Flexible Benefit Plan (including Limited Medical Flexible Spending Account and HSA) with Beniversal® MasterCard® Prepaid Card Summary Plan Description" from Beniversal

HSA Plan

- Booklet entitled “Flexible Benefit Plan (including Limited Medical Flexible Spending Account and HSA) with Beniversal® MasterCard® Prepaid Card Summary Plan Description” from Beniversal

Long-Term Disability Benefits:

- Booklet entitled “Certificate and Summary Plan Description – Group Long Term Disability Insurance” from Standard Life Insurance Company

Short-Term Disability Benefits:

- Booklet entitled “Certificate – Short Term Disability Income Benefit Plan” from Standard Life Insurance Company

Group Life Insurance and AD&D Insurance Benefits:

- Booklet entitled “Certificate and Summary Plan Description – Group Life Insurance” from Standard Insurance Company

Retiree Health Reimbursement Plan

- Booklet entitled “Evraz North America Retiree Health Reimbursement Plan”

Appendix B

CLAIM APPEAL PROCEDURES

NOTE: The following procedures only apply if the particular Welfare Benefit Program does not provide for a claims appeal procedure that satisfies the requirements of ERISA and the regulations thereunder. You should contact the Claims Administrator and the Plan Administrator before instigating an appeal under these procedures.

I. Definitions.

A. "Urgent Care Claim" means any claim for medical care or treatment with respect to which medical care decisions, if made on a non-urgent timeframe, (i) could seriously jeopardize the life or health of the Claimant, (ii) could seriously jeopardize the Claimant's ability to regain maximum function, or (iii) in the opinion of a physician knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

B. "Pre-Service Claim" means any claim for a health benefit under the Plan, if the Plan conditions receipt of such benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

C. "Post-Service Claim" means any claim for a health benefit under the Plan, other than an Urgent Care Claim or a Pre-Service Claim.

D. "Disability Claim" means any claim for disability benefits under the Plan, such as short-term or long-term disability benefits, to the extent offered under the Plan.

E. Non-Health Claim" means any claim for benefits under the Plan that is not a claim for disability benefits or health benefits (e.g., AD&D and life insurance benefits).

F. "Claims Administrator" means the Insurer (or its authorized agent) for those Welfare Benefit Programs that are fully insured or the third party administrator designated by the Plan Administrator for those Welfare Benefit Programs that are self-insured.

G. "Claimant" means any Participant or authorized representative making a request for benefits in accordance with the Plan's claim procedures.

II. Initial Claim Denial.

A. Submitting the Claim. Upon request, the Claims Administrator shall provide any Claimant with a claim form which the Claimant may use to request benefits.

B. Denial of Initial Claim. If a claim for benefits is denied (in whole or in part) by the Claims Administrator, the Claims Administrator shall provide the Claimant with written notification of such denial. The notice of denial of the claim shall include:

1. The specific reason(s) that the claim was denied, including (in the case of any claims other than Non-Health Claims) an explanation of any scientific or clinical judgement exercised as part of the

2. A reference to the specific plan provisions, and, with respect to any claims other than Non-Health Claims, any internal rules, guidelines, protocols, standards, or other similar criteria on which the denial was based.

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

4. A description of any additional material or information necessary to perfect the claim, and an explanation of why this material or information is necessary.

5. A description of the Plan's appeal procedures and the time limits that apply to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA § 502(a) if the claim is denied on appeal.

6. With respect to any claims other than Non-Health Claims, any materials such as an internal rule, protocol, standard, guideline, medical necessity limitation, experimental treatment limitation, or similar criteria that were the basis for the claim being denied (or, in the case of a Disability Claim, a statement that no such materials were relied upon).

7. In the case of an Urgent Care Claim, a description of the expedited appeal procedures.

The Claimant (or his duly authorized representative) may review pertinent documents and submit issues and comments in writing to the Claims Administrator. The Claimant may appeal the denial as set forth in the next section of this procedure. IF THE CLAIMANT FAILS TO APPEAL SUCH ACTION TO THE CLAIMS ADMINISTRATOR IN WRITING WITHIN THE PRESCRIBED PERIOD OF TIME DESCRIBED IN SECTION III BELOW, THE CLAIMS ADMINISTRATOR'S DENIAL OF A CLAIM SHALL BE FINAL, BINDING, AND CONCLUSIVE.

B. Timing of Notice of Denial. The notice required by the previous section must be provided within the following time frames, unless special circumstances require an extension of time for processing the claim. (See Section IV for the procedure concerning extensions of time.)

1. For an Urgent Care Claim – no more than 72 hours after receipt of the claim by the Plan. Notice of denial of an urgent care claim may be provided orally within this time frame, provided that the written notice described in the previous section is provided no less than three days after the oral notification.

2. For a Pre-Service Claim – no more than 15 days after receipt of the claim by the Plan.

3. For a Post-Service Claim – no more than 30 days after receipt of the claim by the Plan.

4. For a Disability Claim – no more than 45 days after receipt of the claim by the Plan.

5. For a Non-Health Claim – no more than 90 days after receipt of the claim by the Plan.

III. Appeal Procedures

A. Filing the Appeal. In the event that a claim is denied (in whole or in part), the Claimant may appeal the denial by giving written notice of the appeal to the Claims Administrator within 180 days after the Claimant receives the notice of denial of the claim. At the same time the Claimant submits a notice of appeal, the Claimant may also submit written comments, documents, testimony, records, and other information relating to the claim. The Claims Administrator shall review and consider this information without regard to whether the information was submitted or considered in conjunction with the initial claim.

B. General Appeal Procedure. The Claims Administrator may ascertain such facts as it deems necessary and shall render a decision which shall be binding upon both parties. In deciding the appeal:

1. No deference shall be given to the decision denying the initial claim.

2. The appeal shall be decided by an individual who did not decide the initial claim, and who is not a subordinate of anyone that decided the initial claim.

3. If the appeal is based in whole or in part on a medical judgment, the individual deciding the appeal shall consult with a health care professional who has appropriate training and experience in the relevant field. The health care professional must not be an individual who participated in the denial of the initial claim, or be the subordinate of any such individual.

4. If the Claims Administrator obtained advice from any medical or vocational experts in conjunction with the initial claim, then such experts must be identified to the Claimant. This identification must occur even if the Claims Administrator did not rely on the advice obtained.

C. Special Appeal Procedure for Urgent Care Claims. In addition to the procedures set forth above, the following shall apply to the appeal of an Urgent Care Claim:

1. A request for expedited review must be made to Claims Administrator either orally or in writing.

2. All necessary information will be transmitted from the Plan to the Claimant by telephone, facsimile or similarly expeditious means.

D. Notice of Decision on Appeal. The appeal decision of the Claims Administrator shall be provided in written form to the Claimant. If the appeal decision is adverse to the Claimant, then the written decision shall include the following:

1. The specific reason or reasons for the appeal decision, including (in the case of any claims other than Non-Health Claims) an explanation of any scientific or clinical judgement exercised as part of the determination.

2. Reference to the specific plan provisions on which the appeal decision is based.

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

4. A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures.

5. A statement of the Claimant's right to bring an action under § 502(a) of ERISA.

6. With respect to any claims other than Non-Health Claims, any materials such as an internal rule, protocol, standard, guideline, medical necessity limitation, experimental treatment limitation, or similar criteria that were the basis for the claim being denied (or, in the case of a Disability Claim, a statement that no such materials were relied upon), and an explanation that the Claimant also will be afforded a reasonable opportunity to respond to any new evidence or rationale relied upon on appeal.

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

8. A notice of any applicable contractual limitations period for bringing a civil action, and its expiration date.

E. Timing of Notice of Decision on Appeal. The Claims Administrator shall render a decision on appeal within the following time frames, unless special circumstances require an extension of time. (See Section IV for the procedures concerning extensions of time.)

1. Urgent Care Claim – no more than 72 hours after receipt of the appeal by the Plan.

2. Pre-Service Claim – no more than 30 days after receipt of the claim by the Plan.

3. Post-Service Claim – no more than 60 days after receipt of the claim by the Plan.

4. Disability Claim – no more than 45 days after receipt of the claim by the Plan.

5. Non-Health Claim – no more than 60 days after receipt of the claim by the Plan.

IV. Extensions of Time

A. Permissible Extensions.

1. For an initial Urgent Care Claim – If the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan, the Claims Administrator shall notify the Claimant, within 24 hours of receipt of the claim, of the specific information necessary to complete the claim. The Claimant shall be permitted not less than 48 hours to provide the specified information. The Claims Administrator shall notify the Claimant of an grant or denial of the claim within 48 hours after the earlier of: (a) the end of

the time period given to the Claimant to provide the specified information or (b) the Plan's receipt of the specified information.

2. For an initial Pre-Service Claim – No more than one extension of 15 days.

3. For an initial Post-Service Claim – No more than one extension of 15 days.

4. For an initial Disability Claim – No more than two extensions of 30 days each.

5. For an initial Non-Health Claim – No more than one extension of 90 days.

6. For an appeal of a Pre-Service Claim – No more than one extension of 30 days.

7. For an appeal of a Post-Service Claim – No more than one extension of 60 days.

8. For an appeal of a Disability Claim – No more than one extension of 45 days.

9. For an appeal of a Non-Health Claim – No more than one extension of 60 days.

B. Notice of Extension. If the Claims Administrator requires an extension of time, the Claims Administrator shall provide the Claimant with written notice of the extension before the first day of the extension. The notice of the extension shall include:

1. An explanation of the circumstances requiring the extension. These circumstances must be matters beyond the control of the Plan Sponsor or the Claims Administrator.

2. The date by which the Claims Administrator expects to render a decision.

3. The standard on which the Claimant’s entitlement to a benefit is based.

4. The unresolved issues, if any, that prevent a decision on the claim or on appeal, and the information needed to resolve those issues. In the event that such information is needed:

a. The Claimant shall have at least 45 days to provide the specified information.

b. The time for determining an initial claim shall be tolled from the date on which the notice of extension is sent to the Claimant, until the date on which the Claimant responds to the request for additional information.

IV. External Review

Depending on the nature of your claim, you may be entitled to external review of your denied appeal. Please review the information set forth in the Notice of Claim Denial for further information.