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WATTERSON ENVIRONMENTAL GROUP HEALTH AND WELFARE PLAN

WRAP PLAN DOCUMENT

Effective January 01, 2025

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WATTERSON ENVIRONMENTAL GROUP HEALTH AND WELFARE PLAN

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WATTERSON ENVIRONMENTAL GROUP HEALTH AND WELFARE PLAN

WRAP PLAN DOCUMENT

Watterson Environmental Group, LLC (the "Employer") hereby adopts the Watterson Environmental Group Health and Welfare Plan (the 'Plan'), effective as of January 01, 2025.

ARTICLE I

Purpose

The purpose of the Plan is to provide to Participants, and their Spouses, Dependents, and Beneficiaries certain welfare benefits described herein. Notwithstanding the number and types of benefits incorporated hereunder, the Plan is, and shall be treated as, a single welfare benefit plan to the extent permitted under ERISA. The Plan is intended to meet all applicable requirements of ERISA and the Code as amended, together with rulings and regulations promulgated thereunder.

ARTICLE II

Definitions

2.1 "ACA" means the Patient Protection and Affordable Care Act of 2010, as amended.

2.2 "Beneficiary" means a beneficiary as defined under a Welfare Program, which may include domestic partners.

2.3 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.4 "Dependent" means dependent as defined under a Welfare Program. However, for purposes of any group health plan listed in Appendix A that provides medical benefits (other than a retiree medical plan) and other Welfare Programs that provide medical benefits, a Dependent shall include a Participant's eligible children who have not attained age 26 (or such later age as determined by the Plan Administrator) and, for Grandfathered Plans, prior to Plan Years beginning before January 1, 2014, who are not eligible to enroll in another employer's medical plan, other than the medical plan of a parent.

2.5 "Effective Date" means January 01, 2025.

2.6 "Employee" means any person providing services to the Employer or a Participating Employer as a common-law employee. To the extent permitted by law, independent contractors (even if re-characterized by the Internal Revenue Service as employees), leased employees within the meaning of Section 414(n) of the Code, and individuals designated by the Employer or Participating Employer as temporary employees shall not be Employees for purposes of this Plan. For purposes of any group health plan incorporated herein, the term Employee shall include any variable hour, temporary or seasonal employees defined as a full-time employee under the ACA.

2.7 "Employer" means Watterson Environmental Group, LLC, and any entity which succeeds to the business and assumes the obligations of the Employer hereunder.

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2.8 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

2.9 "Former Employee" means any person formerly employed as an Employee.

2.10 "Grandfathered Plan" means the term as it is defined in the Department of Labor Regulations, 29 C.F.R. § 2590.715-1251.

2.11 "Leave of Absence" means a personal leave, medical leave or military leave, as approved by the Employer.

2.12 "Participant" means any Employee or Former Employee who satisfies the requirements of Article III of the Plan, has chosen to participate in the Plan and whose participation has not terminated in accordance with Section 3.3.

2.13 "Participant Contribution" means the pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term "Participant Contribution" includes contributions used for the provision of benefits under a self-insured arrangement of the Employer as well as contributions used to purchase insurance contracts or policies.

2.14 "Participating Employer" means any member of the following group including the Employer, if such member adopts the Plan with the Employer's authorization as provided in Section 10.1: (i) a controlled group of corporations, within the meaning of Section 414(b) of the Code; (ii) a group of trades or businesses under common control, within the meaning of Section 414(c) of the Code; (iii) an affiliated service group, within the meaning of Section 414(m) of the Code; or (iv) a trade or business required to be aggregated pursuant to Section 414(o) of the Code. Each Participating Employer is identified in Appendix B. The Employer shall amend Appendix B as needed, to reflect a Participating Employer's adoption of the Plan or withdrawal from the Plan, without any need to otherwise amend the Plan. Amendment of Appendix B may be made by any authorized officer or representative of the Employer and shall not require approval of the Board of Directors.

2.15 "Plan" means the Watterson Environmental Group Health and Welfare Plan, as set forth herein and each Welfare Program incorporated hereunder by reference, as amended from time to time.

2.16 "Plan Administrator" means the Employer or such other individual, committee or firm as the Employer shall designate from time to time.

2.17 "Plan Year" means the twelve consecutive month period ending on December 31.

2.18 "Spouse" means a spouse as defined under a Welfare Program. Notwithstanding anything to the contrary contained herein, the term "Spouse" shall include a same-sex spouse who is legally married under applicable law.

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2.19 "Welfare Program" means a written arrangement incorporated into this Plan that is offered by the Employer which provides an employee benefit, including those that would be treated as an "employee welfare benefit plan" under Section 3(l) of ERISA if offered separately. Welfare Program also means any plan established pursuant to Section 125 or Section 132(f) of the Code. Each Welfare Program under the Plan is identified in Appendix A which is incorporated into and a part of the Plan. The documents for each Welfare Program are incorporated into this document. The Employer may add or delete a Welfare Program from the Plan by amending Appendix A, without any need to otherwise amend the Plan. Amendment of Appendix A may be made by any authorized officer or representative of the Employer and shall not require approval by the Employer's Board of Directors.

In the event that the provisions of any Welfare Program conflict with or contradict the provisions of this document or any other Welfare Program, the Plan Administrator shall use its discretion to interpret the terms and purpose of the Plan, including the written terms and provisions of any Welfare Program document, so as to resolve any conflict or contradiction. However, the terms of this document may not enlarge the rights of a Participant, Spouse, Dependent or Beneficiary to benefits available under any Welfare Program.

ARTICLE III

Eligibility and Participation

3.1 Eligibility. (a) An Employee shall be eligible to participate in the Plan only as specified in a particular Welfare Program listed in Appendix A. An eligible Employee does not include any individual who is in a division, department, unit, or job classification designated by the Employer as not benefit-eligible, regardless of the Employee's work schedule or number of hours worked, unless the Employee is included in the employer shared responsibility penalty calculations, as defined under the ACA, and the Plan Administrator elects to include such Employees as Eligible Employees. The Welfare Program may also designate those Spouses, Dependents, Domestic Partners or Beneficiaries, if any, eligible to receive benefits from the Plan and set forth the criteria for their becoming covered hereunder.

(b) If the Employer has the equivalent of 50 or more full-time Employees, to the extent required by the ACA and other applicable federal law, an Employee shall be eligible to participate in the Employer's group health plan if, in addition to meeting other applicable criteria, the Employee is a full-time Employee who is employed an average of at least 32 hours of service per week with the Employer.

Full-time Employee status for group health plan coverage purposes will be determined in accordance with the measurement rules as specified by the federal government and as adopted by the Employer for all Employees (including variable hour, temporary and seasonal employees, if such classes exist within the Employer). Full-time Employee status does not include any temporary employee who is eligible for group health plan coverage through a leasing organization, unless otherwise required by the ACA and the Employer. Determination of full-time Employee status will be made by the Plan Administrator, in its sole and absolute discretion, in accordance with the Plan and the Employer Shared Responsibility provisions of the ACA.

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3.2 Enrollment. The Plan Administrator shall establish procedures in accordance with the Welfare Programs for the enrollment of eligible Employees, their Spouses or Dependents, if any, under the Plan. The Plan Administrator shall prescribe enrollment forms that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.

3.3 Termination of Participation. A Participant shall cease being a Participant in the Plan and coverage under this Plan for the Participant, his or her Spouse, Dependents and Beneficiaries, if any, shall terminate in accordance with the provisions of the Welfare Programs and the ACA.

ARTICLE IV

Funding and Benefits

4.1 Funding. (a) Notwithstanding anything to the contrary contained herein, participation in the Plan and the payment of Plan benefits attributable to Employer or Participating Employer contributions shall be conditioned on a Participant contributing to the Plan at such time and in such amounts as the Plan Administrator shall establish from time to time ("Participant Contribution"). The Plan Administrator may require that any Participant Contributions be made by payroll deduction. Nothing herein requires the Employer, Participating Employer or the Plan Administrator to contribute to or under any Welfare Program, or to maintain any fund or segregate any amount for the benefit of any Participant, Spouse, Dependent, Domestic Partner or Beneficiary, except to the extent specifically required under the terms of a Welfare Program. No Participant, Spouse, Dependent, Domestic Partner or Beneficiary shall have any right to, or interest in, the assets of the Employer or Participating Employer.

(b) The Employer shall have no obligation, but shall have the right, to insure or reinsure, or to purchase stop loss coverage with respect to any Welfare Program under this Plan. To the extent the Employer elects to purchase insurance with respect to any Welfare Program, any benefits to be provided under such Welfare Program shall be the sole responsibility of the insurer, and the Employer or Participating Employer shall have no responsibility for the payment of such benefits (except for refunding any Participant Contributions that were not remitted to the insurer). Except as otherwise permitted by rulings or regulations under ERISA, any Participant Contributions shall be remitted to the appropriate insurer, as soon as practicable but not later than 90 days after such contributions are made and would otherwise have been paid to Participants in cash.

4.2 Benefits. Benefits will be paid solely in the form and amount specified in the relevant Welfare Program and pursuant to the terms of such Welfare Program.

ARTICLE V

Plan Administration and Fiduciary Duties

5.1 Named Fiduciary. The Plan Administrator shall be the "named fiduciary" of the Plan, as defined in Section 402(a)(2) of ERISA, unless the Employer appoints a replacement.

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5.2 Plan Administration. Except as otherwise provided in a Welfare Program:

(a) The Plan Administrator shall have sole discretion and authority to control and manage the operation and administration of the Plan.

(b) The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.

(c) The Plan Administrator shall have all other powers necessary or desirable to administer the Plan, including, but not limited to, the following:

(i) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;

(ii) To prepare and distribute information explaining the Plan to Participants;

(iii) To receive from the Employer (or Participating Employer) and Participants, Spouses, Dependents and Beneficiaries such information as shall be necessary for the proper administration of the Plan;

(iv) To keep records of elections, claims, disbursements for claims under the Plan, and any other information required by ERISA or the Code;

(v) To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents it deems advisable;

(vi) To purchase any insurance deemed necessary for providing benefits under the Plan;

(vii) To accept, modify or reject Participant elections under the Plan;

(viii) To promulgate election forms and claims forms to be used by Participants;

(ix) To prepare and file any reports or returns with respect to the Plan required by the Code, ERISA or any other laws;

(x) To determine and announce any Participant Contributions required hereunder;

(xi) To determine and enforce any limits on benefits elected hereunder;

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(xii) To take such action as may be necessary to cause any required payroll deduction of any Participant Contributions required hereunder; and

(xiii) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan; specifically, and without limitation, to recover erroneous overpayments made from the Plan to a Participant, Spouse, Dependent or Beneficiary, in whatever manner the Plan Administrator determines is appropriate, including recoupment of past payments, or offsets against, future payments due that Participant, Spouse, Dependent or Beneficiary.

(d) The Plan Administrator shall have sole discretion and authority regarding the distribution, or other use, of dividends, demutualization and/or the Medical Loss Ratio rebates, if any, from group health insurers.

5.3 Delegation of Duties. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan, may designate fiduciaries other than those named in the Plan, and may allocate or reallocate fiduciary responsibilities under the Plan.

5.4 Indemnification. The Plan Administrator and any delegate who is an employee of the Employer or Participating Employer shall be fully indemnified by the Employer and each Participating Employer against all liabilities, costs, and expenses (including defense costs, but excluding any amount representing a settlement unless such settlement is approved by the Employer) imposed upon it in connection with any action, suit, or proceeding to which it may be a party by reason of being the Plan Administrator or having been assigned or delegated any of the powers or duties of the Plan Administrator, and arising out of any act, or failure to act, that constitutes or is alleged to constitute a breach of such person's responsibilities in connection with the Plan, unless such act or failure to act is determined to be due to gross negligence or willful misconduct.

5.5 Fiduciary Duties and Responsibilities. Each Plan fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of each Participant, Spouse, Dependent and Beneficiary; for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of administering the Plan; and in accordance with the terms of the Plan. Each fiduciary, in carrying out such duties, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in exercising such authority. A fiduciary may serve in more than one fiduciary capacity. Unless liability is otherwise provided under Section 405 of ERISA, a named fiduciary shall not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a named fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

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ARTICLE VI

Claims and Subrogation

6.1 Claims Procedure. Except as provided in Sections 6.2, 6.3 and 6.4, a claim for benefits under a Welfare Program shall be submitted in accordance with and to the party designated under the terms of such Welfare Program.

6.2 Claims Procedures for Group Health Plans. (a) This Section is intended to comply with Department of Labor Regulations, 29 C.F.R. §§ 2560.503-1 and 2590.715-2719, and shall apply specifically to claims under a group health plan as defined in Department of Labor Regulation 29 C.F.R. § 2560.503-1. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the Welfare Program, the claims procedure in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure, provided such other claims procedure complies with Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719. In accordance with those regulations, all claims and appeals for group health plan benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Notwithstanding any provision of this Article VI, a group health plan that is a Grandfathered Plan is not subject to the claims and appeals procedures under Department of Labor Regulation § 2590.715-2719.

(b) Written Claim for Benefits. If a claimant asserts a right to any benefit under the Plan, the claimant must file a written claim for such benefit with the Plan Administrator. For purposes of this Section, claimant shall mean any Participant, Spouse, Dependent, or Beneficiary or authorized representative who files a claim for group health plan benefits under the Plan.

(c) Benefit Determinations. All adverse benefit determinations referenced below shall be written in a culturally and linguistically appropriate manner, and shall include the information required by Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(i) Post-Service Claims. A post-service claim is any claim that is filed for payment of benefits after health care has been received.

(A) Upon the denial of a post-service claim, the Plan Administrator shall notify the claimant in writing of such denial within 30 days of receipt of the claim. The Plan Administrator shall be permitted one 15-day extension to the 30-day claim determination period, provided that the Plan Administrator determines that such extension is necessary due to matters beyond the Plan's control and notifies the claimant before the end of the initial 30-day period of the circumstances necessitating the extension of time and the date by which the Plan intends to render a decision. If such extension is required due to the claimant's failure to submit all information necessary to decide the claim, the extension notification must specifically describe the required information and the claimant shall have 45 days from receipt of the notice to provide the requested information. Failure by the

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claimant to provide requested information shall result in the denial of the claim.

(B) A denial notice shall explain the reason(s) for denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(C) The time period to consider a post-service claim shall be suspended from the date any notification of extension is sent to the claimant until the claimant fulfills any request for additional information.

(ii) Pre-Service Claims. A pre-service claim is any claim for benefits that requires certification or approval prior to the performance of the requested health care service.

(A) Upon receiving a pre-service claim, the Plan Administrator shall notify the claimant in writing of the Plan's benefit determination within a reasonable period but no later than 15 days after receipt of the claim. The Plan Administrator shall be permitted one 15-day extension provided that the Plan Administrator determines that such extension is necessary due to matters beyond the Plan Administrator's control and notifies the claimant before the end of the initial 15-day period of the circumstances necessitating the extension of time and the date by which the Plan intends to render a decision. The Plan Administrator shall, within 5 days of receiving any deficient claim, notify the claimant of such deficiency and the steps necessary to correct the claim. Notification may be oral unless the claimant requests written notification. The claimant shall have 45 days from receipt of the notice to provide the requested information. Failure by the claimant to provide requested information shall result in the denial of the claim.

(B) A denial notice shall explain the reason(s) for the denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(C) The time period to consider a pre-service claim shall be suspended from the date any notification of extension is sent to the claimant until the claimant fulfills any request for additional information.

(iii) Urgent Care Claims. An urgent care claim is a claim that requires notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize the claimant's life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of the claimant's health condition, could cause severe pain.

(A) An urgent care claimant shall receive notice of the benefit determination in writing or electronically as soon as possible,

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but no later than 72 hours (or such other time as prescribed in Department of Labor Regulations) after the Plan Administrator receives all necessary information, taking into account the severity of the claimant's condition. Notice of denial may be oral with a written or electronic confirmation to follow within 3 days. If the claimant files an urgent care claim improperly, the Plan Administrator, within 24 hours after the claim is received, shall notify the claimant of the improper filing and how to correct it. The claimant shall have 48 hours (or such other time as prescribed in Department of Labor Regulations) to provide the requested information and shall be notified of a determination no later than 48 hours after receipt of the corrected claim or the end of the 48-hour period afforded to the claimant to provide the requested additional information.

(B) A denial notice shall explain the reason(s) for the denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(iv) Concurrent Care Claims.

(A) Any request by a claimant to extend an on-going course of treatment beyond a previously approved specified period of time or number of treatments, that is an urgent care claim as defined in paragraph (iii), shall be decided as soon as possible, and the Plan Administrator shall notify the claimant of the determination within 24 hours of receipt of the claim, provided the claim is made at least 24 hours prior to the end of the approved period of time or number of treatments. If the claimant's request for extended urgent care treatment is not made at least 24 hours prior to the end of the approved treatment, the request shall be treated as an urgent care claim in accordance with paragraph (iii).

(B) If an on-going course of treatment was previously approved for a specified period of time or number of treatments, and the claimant's request to extend treatment is non-urgent, the claimant's request shall be considered a new claim and decided in accordance with post-service or pre-service timeframes, as applicable.

(d) Appeal of Claim Denial.

(i) Any claimant shall have the right to appeal an "adverse benefit determination" as defined in Department of Labor Regulation 29 C.F.R. § 2590.715-2719 within 180 days of receipt of such adverse benefit determination. Any appeal shall be submitted to the Plan Administrator in writing. If the appeal relates to a claim for payment, the claimant's request should include: the patient's name and plan identification number; the date(s) of health care service(s); the provider's name; the reason(s) the claimant believes the claim should be paid; and any documentation or other written information to support the claimant's request for claim payment.

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(ii) An appeal shall be determined by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor a subordinate of that individual. If the appeal is related to medical matters, the appeal shall be reviewed in consultation with an independent and impartial health care professional who has appropriate training and experience in the particular field of medicine in order to make the health care judgment and who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, independent and impartial medical experts as part of the appeal resolution process. The claimant consents to this referral and the sharing of pertinent health claim information. The claimant shall have the right to review and respond to any new or additional evidence or rationales considered, relied upon, or generated by the Plan or other person making the benefit determination before the Plan issues an adverse benefit determination on appeal. Upon request and free of charge the claimant has the right to reasonable access to and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(iii) The claimant shall be notified of the Plan Administrator's decision upon review as appropriate, in accordance with the content and timing requirements of Department of Labor Regulations, 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(iv) Upon being notified of an adverse determination under an appeal, the claimant shall be permitted, within 60 days of receiving notice of such determination, to submit notice of a "second-level appeal" to the Plan Administrator. A second-level appeal shall be decided in accordance with the rules in paragraph (ii).

(e) Timeframes for Appeals Determinations.

(i) Pre-Service Claim Appeal. The Plan Administrator shall have 15 days, upon receiving notice of appeal (or second-level appeal) of the denial of benefits under a pre-service claim, to notify the claimant electronically or in writing of the appeal determination.

(ii) Post-Service Claim Appeal. The Plan Administrator shall have 30 days, upon receiving notice of appeal (or second-level appeal) of the denial of benefits under a post-service claim, to notify the claimant electronically or in writing of the appeal determination.

(iii) Urgent Care Claim Appeal. Upon receiving a notice to appeal (or second-level appeal) the determination of a claim involving urgent care, the Plan Administrator shall notify the claimant of the appeal determination as soon as possible, taking into account medical exigencies surrounding the claim, but no later than 72 hours (or such other time as prescribed in Department of Labor Regulations). Notice shall be given to the claimant by telephone, facsimile, or other similarly expeditious manner. Oral communications shall be followed up in writing.

(iv) The Plan Administrator has the exclusive right to interpret and administer the provisions of the Plan and its decisions with respect to claims are conclusive and binding.

(f) External Appeals. Except as otherwise required by applicable law, if a Participant exhausts all internal appeals procedures, the Participant may commence an external review. The external review process will comply with applicable state or federal law and other rules

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and procedures for non-Grandfathered Plans as prescribed in Department of Labor Regulation 29 C.F.R. § 2590.715-2719.

6.3 Claims Procedure for Benefits Based on Determination of Disability. (a) This Section shall apply to any claim made under a Welfare Program which bases benefits on a determination of disability. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the Welfare Program, the claims procedure in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure as long as such other claims procedure complies with Department of Labor Regulation 29 C.F.R. § 2560.503-1. In accordance with that regulation, all claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

(b) If a claim for benefits based on a determination of disability is denied in whole or in part, the claimant or the claimant's Beneficiary shall receive written notification of the "adverse benefit determination" as defined in 29 C.F.R. § 2560.503-1 in a culturally and linguistically appropriate manner. A denial notice shall explain the reason(s) for the denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulation 29 C.F.R. § 2560.503-1. Among other requirements, that regulation requires denial notices for disability claims to include:

(i) a discussion of the decision, including, if applicable, the basis for disagreeing with or not following the views of health care and vocational professionals who evaluated the claimant, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, or with a disability benefit determination regarding the claimant made by the Social Security Administration;

(ii) the internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were relied upon in denying the claim or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

(iii) if applicable, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iv) 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.

Claimants will receive adverse benefit determinations within a reasonable period of time, but no later than 45 days after the Plan Administrator's receipt of the claim. The Plan Administrator may extend this period for up to 30 additional days provided the Plan Administrator determines that the extension is necessary due to matters beyond the Plan Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Plan Administrator expects to render a decision. The 30-day

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extension can be extended by an additional 30 days if the Plan Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. Any notice of extension must be sent to the claimant before the end of the initial 30-day period, and shall explain the circumstances requiring the extension, the date by which the Plan Administrator expects to render a decision, the standards on which the claimant's entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, the claimant must submit. The claimant shall be provided with at least 45 days to provide the additional information. The period from which the claimant is notified of the additional required information to the date the claimant responds is not counted as part of the determination period.

(c) The claimant shall have 180 days to appeal an adverse benefit determination. The claimant shall have the right to review and respond to any new or additional evidence or rationales considered, relied upon, or generated by the Plan or other person making the benefit determination before the Plan issues an adverse benefit determination on appeal. The claimant shall be notified of the Plan Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Plan Administrator receives the claimant's appeal request. The Plan's adverse benefit determination on review shall include the information required by Department of Labor Regulation 29 C.F.R. § 2560.503-1. Among other requirements, this adverse benefit determination must include a statement of the claimant's right to bring a lawsuit in federal court and a description of any applicable contractual limitations period that applies to the claimant's right to bring a lawsuit and its expiration date.

The 45-day period may be extended for an additional 45-day period if the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time and provided that the claimant is notified of the extension prior to the expiration of the initial 45-day period. Such notice shall state the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

(d) The time period to consider a claim for benefits based on a determination of disability or to consider an appeal of an adverse benefit determination shall be suspended from the date any notification of extension is sent to the claimant or appellant until such individual fulfills such request for additional information.

6.4 Claims Procedure for Benefits Other Than Health Benefits or Those Based on Determination of Disability.

(a) If the Welfare Program does not describe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA, or the Plan Administrator determines that the procedures described in Sections 6.2 or 6.3 with respect to a particular Welfare Program shall not apply, the claims procedure described in this Section shall apply with respect to such Welfare Program if the Welfare Program is subject to ERISA. If the Welfare Program is not subject to ERISA as determined by the Plan Administrator, then the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the Welfare Program shall supersede this procedure.

(b) If a Participant or former Participant asserts a right to any benefit under the Plan that the Participant has not received, the Participant or his or her authorized representative shall file a written claim for such benefit with the Plan Administrator. If the Plan Administrator

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wholly or partially denies such claim, it shall provide written or electronic notice to the claimant within a reasonable period of time, but not later than 90 days after receipt by the Plan Administrator of the claim, unless the Plan Administrator determines that special circumstances require an extension of time, not to exceed 90 days, for processing the claim. If the Plan Administrator determines that an extension of time is required, it shall provide the claimant with written notice of the extension before the end of the initial 90-day period. Such notice shall describe the special circumstances requiring the extension of time and specify the date by which the Plan Administrator expects to render a benefit determination. If the Plan Administrator wholly or partially denies a claim, it shall set forth in its benefit determination, which shall be written in a manner calculated to be understood by the claimant:

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

(ii) specific reference(s) to pertinent provisions of the Plan on which the adverse benefit determination is based;

(iii) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;

(iv) an explanation of the Plan's claims review procedure, including the time limits applicable under such procedure; and

(v) a statement that the claimant has the right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

(c) A Participant or former Participant whose claim for benefits is denied may request a full and fair review of the adverse benefit determination within 60 days after notification of the adverse benefit determination by the Plan Administrator. The Participant or former Participant:

(i) shall be provided a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination;

(ii) shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim; and

(iii) may submit written comments, documents, records and other information relating to the claim to the Plan Administrator for review.

(d) Subject to Department of Labor Regulation 29 C.F.R. § 2560.503-1(i)(1)(ii), a decision on review by the Plan Administrator shall be made within a reasonable period of time, but not later than 60 days after receipt by the Plan Administrator of a request for review, unless special circumstances (such as the need to hold a hearing) require an extension of time for processing, in which case the claimant shall be provided with written notice of the extension before the end of the initial 60-day period. Such notice shall describe the special circumstances requiring the extension and specify the date by which the Plan Administrator expects to render its decision. In no event shall the decision be rendered later than 120 days after receipt of the request for review.

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(e) The Plan Administrator shall provide written or electronic notice of its decision with respect to the claimant's appeal which shall be written in a manner calculated to be understood by the claimant. If there is an adverse benefit determination on review, the Plan Administrator's decision shall include:

(i) the specific reasons for the adverse benefit determination;

(ii) specific reference(s) to pertinent provisions of the Plan on which the adverse benefit determination is based;

(iii) 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 claim;

(iv) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to receive information about any such procedures; and

(v) a statement that the claimant has the right to bring a civil action under Section 502(a) of ERISA following the adverse benefit determination on review.

6.5 Unclaimed Benefits. If, within one year after any amount becomes payable hereunder to a Participant, Spouse, Dependent or Beneficiary and the same shall not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care shall have been exercised by the Plan Administrator in attempting to make such payments, the amount thereof shall be forfeited and shall cease to be a liability of the Plan.

6.6 Right of Subrogation.

(a) Definitions. For purposes of this Section, the following definitions shall apply:

(i) Award. "Award" means any amount paid to or on behalf of a Covered Individual, from a Third Party with respect to a Covered Individual's Illness, Injury or other loss regardless of whether such amount is received as a result of a judgment of a court of competent jurisdiction, settlement, compromise or otherwise and regardless of whether such amount is categorized as punitive, compensatory, reimbursement for medical expenses, or otherwise.

(ii) Covered Individual. "Covered Individual" includes the individual for whom benefits are paid by the Plan and his or her heirs, guardians, executors or other representatives.

(iii) Injury or Illness. "Injury" or "Illness" means such term as defined in each Welfare Program.

(iv) Reimbursement. "Reimbursement" means the Plan's right to recover any and all amounts paid for medical expenses from a Covered Individual who receives any award related to the Illness, Injury or other loss that resulted in the payment of such benefits by the Plan.

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(v) Subrogation. "Subrogation" means the right of the Plan to be substituted in place of any Covered Individual with respect to that Covered Individual's lawful claim, demand, or right of action against a Third Party who may have wrongfully caused the Covered Individual's Injury, Illness or other loss that resulted in a payment of benefits by the Plan.

(vi) Third Party. "Third Party" includes, but is not limited to, any person or entity that caused, contributed to, or may be responsible for the Injury, Illness or other loss to the Covered Individual. Third Party shall include any party, such as an insurance company, that acquires or may acquire responsibility through the actions of such person or entity, and shall also include uninsured motorist coverage.

(b) Subrogation, Reimbursement and Benefit Offsets. For any and all benefits paid by the Plan to or on behalf of a Covered Individual by reason of Illness, Injury or other loss, the Plan shall have the following rights:

(i) Subrogation to any and all rights of recovery the Covered Individual may have arising from such Injury, Illness or other loss;

(ii) Reimbursement for the amount of any and all benefits paid to or on behalf of the Covered Individual by reason of Injury, Illness or other loss with respect to which the Plan has a right to Subrogation pursuant to paragraph (i) above from any Award arising out of such Injury, Illness or other loss; and

(iii) Benefit offsets of future claims payable by the Plan on behalf of the Covered Individual or members of such Covered Individual's immediate family to recover any and all amounts paid to or on behalf of the Covered Individual by reason of such Illness, Injury or other loss with respect to which the Plan has a right to Subrogation pursuant to paragraph (i) and a right to Reimbursement pursuant to paragraph (ii) but which have not, for any reason whatsoever, been reimbursed to or recovered by the Plan.

The Plan's subrogation/reimbursement/benefit offset rights (herein referred to collectively as "Recovery Rights") shall include the right to recover the amount due and owing to the Plan pursuant to its Recovery Rights from any Award paid to or for the benefit of the Covered Individual. The Plan does not recognize the "make whole" rule and a Covered Individual may not be whole after the Plan's Recovery Rights are satisfied.

(c) Payment Prior to Determination of Responsibility of a Third Party. The Plan does not cover nor is it liable for any expenses for services or supplies incurred by a Covered Individual for any Illness, Injury or other loss which a Third Party caused, contributed to or may be responsible for to the extent that the Covered Individual receives any Award from any Third Party. However, subject to the terms and conditions of this Section, the Plan will, after receipt of an executed reimbursement/subrogation/assignment agreement on such form as the Plan Administrator may require, make advance payment of benefits in accordance with the terms of the Plan, until an Award is paid to or for the benefit of the Covered Individual by a Third Party with respect to such Illness, Injury or loss. The terms and provisions of such reimbursement/subrogation/assignment agreement are incorporated herein by reference and any such agreement shall constitute a part of the Plan.

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By accepting an advance payment of benefits from the Plan, the Covered Individual(s) jointly and severally agree that:

(i) the Plan has a priority lien against any Award paid to or on behalf of the Covered Individual to assure that Reimbursement is promptly made; and

(ii) the Plan will be subrogated to such Covered Individual's right of recovery from any Third Party to the extent of the Plan's advance payment of benefits; and

(iii) such Covered Individual(s) will, jointly and severally, reimburse the Plan out of any and all Awards paid or payable to such Covered Individual(s) by any Third Party to the extent of the Plan's advance payment of benefits for claims related to the Illness, Injury or other loss; and

(iv) such Covered Individual(s) will assign to the Plan all of their right, title and interest in and to any Award paid to or on their behalf by any Third Party to the extent of any advance payment of benefits made or to be made in accordance with the terms of the Plan.

The Plan's Recovery Rights include but are not limited to all claims, demands, actions and rights of recovery of all Covered Individuals against any Third Party, including any workers' compensation insurer or governmental agency, and will apply to the extent of any and all advance payment of benefits made or to be made by the Plan.

(d) Recovery Actions. The Plan may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its Recovery Rights, and may try or settle any such action or proceeding in the name of and with the full cooperation of the Covered Individual. However, in doing so, the Plan will not represent, or provide legal representation for, any Covered Individual with respect to such Covered Individual's damages to the extent those damages exceed any advance payment of benefits made or to be made in accordance with the terms of this Plan.

The Plan may, at its discretion, intervene in any claim, legal action, or administrative proceeding started by any Covered Individual against any Third Party on account of any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Individual's Illness, Injury or other loss that resulted in any advance payment of benefits by the Plan.

(e) Reimbursement/Subrogation/Assignment Agreement. Prior to the advance payment of benefits for which a Third Party may be responsible, the Covered Individual on whose behalf an advance payment of benefits may be payable must execute and deliver any and all agreements, instruments and papers requested by or on behalf of the Plan including an executed reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require. The failure of a Covered Individual to execute any such reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require, for any reason, shall not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's Recovery Rights if the Plan, at its discretion, makes an advance payment of benefits for any reason in the absence of a reimbursement/subrogation/assignment agreement.

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(f) Administrative Procedure. The Plan's standard administrative procedure will be to determine whether a Third Party could be held liable for a claim. Claims will not be paid until this determination is made. If it is determined that the claim may be the responsibility of a Third Party for any reason, the Plan will not process any claims without a properly signed reimbursement/subrogation/assignment agreement as described in this Section.

(g) Cooperation with the Plan by All Covered Individuals. By accepting an advance payment of benefits, the Covered Individual agrees not to do anything that will waive, compromise, diminish, release or otherwise prejudice the Plan's Recovery Rights and to do whatever is necessary to protect the Plan's Recovery Rights.

By accepting an advance payment for benefits the Covered Individual agrees to notify and consult with the Plan Administrator or its designee before:

(i) starting any legal action or administrative proceeding against a Third Party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Individual's Illness, Injury or other loss that resulted in the Plan's advance payment for benefits; or

(ii) entering into any settlement agreement with a Third Party that may be related to any actions by the Third Party that may have caused or contributed to the Covered Individual's Illness, Injury or other loss that resulted in the Plan's advance payment for benefits related to such Illness, Injury or other loss.

Furthermore, by accepting an advance payment of benefits, the Covered Individual agrees to keep the Plan Administrator or its designee informed of all material developments with respect to all such claims, actions or proceedings.

The Plan's Recovery Rights are Plan assets. The Plan or its designee may institute a lawsuit against a Covered Individual if such Covered Individual does not adequately protect the Plan's Recovery Rights.

(h) All Recovered Proceeds Are to be Applied to Reimburse the Plan. By accepting an advance payment of benefits for an Illness, Injury or other loss, the Covered Individual agrees to reimburse the Plan for all such advances from any Award paid or payable to or on behalf of such Covered Individual by any Third Party. In such event, the Plan must be fully reimbursed within 31 days or the Covered Individual will be liable for interest and all costs of collection, including reasonable attorney's fees.

If a Covered Individual fails to reimburse the Plan as required by this Section, the Plan may apply any future claims for benefits that may become payable on behalf of such Covered Individual or any member of such Covered Individual's immediate family to the amount not reimbursed.

Notwithstanding anything contained in the Plan to the contrary, the Plan will not pay future benefits for claims related to an Illness, Injury or other loss with respect to which an Award was paid to or on behalf of a Covered Individual unless the Plan Administrator determines that the Award was reasonable and the subsequent claims were not recognized in the Award.

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(i) Pre-Emption of State Law. To the extent that this Plan is a self-insured employee welfare benefit plan, ERISA preempts any state law purporting to limit, restrict or otherwise alter the Plan's Recovery Rights.

(j) No-Fault Insurance Coverage. Notwithstanding anything contained in the Plan to the contrary, if a Covered Individual is required to have no-fault automobile insurance coverage, the automobile no-fault insurance carrier will initially be liable for any and all expenses paid by this Plan up to the greater of:

(i) the maximum amount of basic reparation benefit required by applicable law, or

(ii) the maximum amount of the applicable no-fault insurance coverage in effect.

The Plan will, thereafter, consider any excess charges and expenses under the applicable provisions of this Plan in which the Covered Individual is provided coverage. Before related claims will be paid through the Plan, the Covered Individual will be required to sign a reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require.

If the Covered Individual fails to secure no-fault insurance as required by state law, the Covered Individual is considered as being self-insured and must pay the amount of any and all expenses paid by the Plan for any and all Covered Individuals arising out of the accident.

(k) Refund of Overpayment of Benefits – Right of Recovery. If the Plan pays benefits for expenses incurred on account of a Covered Individual, the Covered Individual or any other person or organization that was paid must make a refund to the Plan if:

(i) all or some of the expenses were not paid, or did not legally have to be paid, by the Covered Individual;

(ii) all or some of the payment made by the Plan exceeds the benefits under the Plan; or

(iii) all or some of the expenses were recovered from or paid by a source other than this Plan, including another plan to which this Plan has secondary liability under the Coordination of Benefits provisions.

This may include payments made as a result of claims against a Third Party for negligence, intentional or otherwise wrongful acts or omissions. The refund shall equal the amount the Plan paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Plan paid.

If a Covered Individual or any person or organization that was paid does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are

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payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

ARTICLE VII

Special Compliance Provisions

7.1 Use and Disclosure of Protected Health Information. (a) Any health plan under the Plan shall use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For purposes of this Section, health plan shall have the meaning as defined in HIPAA. Specifically, any health plan shall use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

(b) Health Care Treatment. Health care treatment means the provision, coordination or management of health care and related services by one or more health care providers. It also includes coordination or management of health care by a health provider and a third party and consultation or referrals between one health care provider and another.

(c) Payment. Payment includes activities undertaken by any health plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits, or to obtain or provide reimbursement for the provision of health care, that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(i) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);

(ii) coordination of benefits;

(iii) adjudication of health claims (including appeals and other payment disputes);

(iv) subrogation of health claims;

(v) establishing employee contributions;

(vi) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(vii) billing, collection activities and related health care data processing;

(viii) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(ix) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

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(x) medical necessity reviews or reviews of appropriateness of care or justification of charges;

(xi) utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(xii) disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

(xiii) reimbursement to a health plan.

(d) Health Care Operations. Health care operations include, but are not limited to, the following activities:

(i) quality assessment;

(ii) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives and related functions that do not include treatment;

(iii) rating provider and health plan performance, including accreditation, certification, licensing or credentialing activities;

(iv) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(v) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(vi) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the health plan, including formulary development or improvement of payment methods or coverage policies; and

(vii) business management and general administrative activities of the health plan, including, but not limited to:

(A) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

(B) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers, provided that protected

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health information is not disclosed to such policyholder, plan sponsor, or customer;

(C) resolution of internal grievances; and

(D) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

(e) A health plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or other covered individual. With an authorization, a health plan shall disclose PHI to pension plans, disability plans, reciprocal benefit plans, and workers' compensation insurers, for purposes related to administration of the health plan.

(f) A health plan shall disclose PHI to the Employer only upon receipt of a certification from the Employer that the health plan documents have been amended to incorporate the following provisions and that the Employer agrees to:

(i) not use or further disclose PHI other than as permitted or required by the health plan document or as required by law;

(ii) ensure that any agents, including subcontractors, to whom the Employer provides PHI received from a health plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(iii) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

(iv) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

(v) report to the health plan's designee any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for;

(vi) make PHI available to an individual in accordance with HIPAA's access requirements;

(vii) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(viii) make available the information required to provide an accounting of disclosures;

(ix) make the Employer's internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services for the purposes of determining the health plan's compliance with HIPAA;

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(x) ensure that adequate separation between the health plan and the Employer is established as required by HIPAA; and

(xi) if feasible, return or destroy all PHI received from the health plan that the Employer maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible).

(g) Only those employees or classes of employees identified in the Plan's privacy policies and procedures may have access to and use and disclose PHI for plan administration functions that the Employer performs for the health plan. If such individuals do not comply with this health plan document, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

(h) Security. The Employer shall implement security measures with respect to PHI to the extent of and in accordance with the security rules implemented by HIPAA. Specifically, the Employer shall:

(i) implement administrative, physical and technical safeguards that will reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the plan;

(ii) ensure the adequate separation between the Plan and the Employer is supported by reasonable and appropriate security measures;

(iii) ensure that any agent, including a subcontractor, to whom it provides information agrees to implement reasonable and appropriate security measures to protect the information (e.g., in the event the Employer provides information to the broker for renewal bids); and

(iv) report to the Plan any security incident of which it becomes aware.

7.2 Special Enrollment Rights. (a) In accordance with the HIPAA special enrollment rules, if an eligible Employee declines coverage in a group health plan for himself or herself and/or the Employee's Spouse and Dependents because of other health insurance coverage, they may be able to enroll in the Plan's group health coverage upon loss of eligibility for the other coverage, provided that the Participant requests enrollment within 30 days after the other coverage ends.

If a Participant gains a new Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and the Participant's Spouse and Dependents in the group health Welfare Program provided that enrollment is requested within 30 days after the marriage, birth, adoption, or placement for adoption.

(b) Employees, Spouses and Dependents who are eligible but not enrolled in a group health plan listed in Appendix A may enroll when:

(i) The Employee's, Spouse's or Dependent's Medicaid or Children's Health Insurance Program ("CHIP") coverage is terminated as a result of loss of eligibility and the

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eligible Employee requests coverage under a group health plan listed in Appendix A within 60 days after the termination, or

(ii) The Employee, Spouse or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP and the eligible Employee requests coverage under a group health plan listed in Appendix A within 60 days after eligibility is determined.

The special enrollment rules of this Section 7.2 do not apply to limited scope dental or vision benefits or certain health care flexible spending accounts (e.g., health care spending accounts that limit benefits to employee salary reduction amounts).

7.3 Qualified Medical Child Support Orders. A qualified medical child support order ("QMCSO") is an order made pursuant to state domestic relations law by a court or a state agency authorized under state law to issue child support orders which requires a group health plan to provide a child or children of an Employee with health insurance coverage. The Plan Administrator shall comply with the terms of any QMCSO it receives, and shall:

(a) Establish reasonable procedures to determine whether a medical child support order is a QMCSO as defined under Section 609 of ERISA (these procedures are available, free of charge, to Participants and Beneficiaries upon request to the Plan Administrator);

(b) Promptly notify the Participant and any alternate recipient of the receipt of a medical child support order, and the group health plan's procedures for determining whether the medical child support order is a QMCSO; and

(c) Within a reasonable period of time after receipt of such order, determine whether such order is a QMCSO and notify the Participant and each alternate recipient of such determination.

7.4 State Medicaid Programs. Eligibility for coverage or enrollment in a state Medicaid Program shall not impact an Employee's, Spouse's or Dependent's eligibility for health coverage or health benefits under the Plan.

7.5 Coverage During FMLA Leave. A Participant on a leave of absence that qualifies as leave under the Family and Medical Leave Act of 1993 ("FMLA") may continue to receive group health plan coverage under this Plan during such leave along with his or her eligible Spouse and Dependents as if such participant did not experience an interruption in active employment until the end of such FMLA leave period, or, if earlier, the date the Participant gives notice that he or she does not intend to return to work at the end of the FMLA period. The Participant must make any required contributions for group health plan coverage during such period in such time and manner as the Plan Administrator may require under applicable federal regulations and in accordance with the terms of any applicable Code Section 125 cafeteria plan sponsored by the Employer.

If a Participant does not continue group health coverage or other types of coverage but returns to work before the expiration of FMLA leave, he or she must be reinstated in his or her benefit coverage, including group health care coverage, at the same level and under the same conditions as if the leave had not occurred.

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7.6 Special Rules for Maternity and Infant Coverage. Any health plan available under the Plan shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The attending provider or physician, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Notwithstanding the foregoing, the health plan and issuers may not require that a provider obtain authorization from the health plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

7.7 Special Rule for Women's Health. If a health benefit plan available under the Plan provides medical and surgical benefits for mastectomy procedures, it shall provide coverage for reconstructive surgery following mastectomies. This expanded coverage includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the health benefit plan or coverage.

7.8 Military Leave.

A Participant's right to elect continued participation in a group health plan available under this Plan for himself or herself, the Participant's Spouse and Dependents during a leave of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

(a) Participants may elect to continue group health plan coverage under the Plan for a period of time that is the lesser of:

(i) the 24-month period beginning on the Participant's first day of military leave, or

(ii) the period beginning on the Participant's first day of military leave and ending on the date the Participant fails to return from military leave or apply for re-employment as required under USERRA.

(b) If a Participant's absence for military duty is less than 31 days, the Participant will be required to pay the regular employee share of the cost for group health plan coverage. If the Participant's absence is for 31 or more days, the Participant will be required to pay not more than 102% of the full cost of the group health plan coverage (and the Participant's Spouse and Dependents) under the Plan.

(c) USERRA continuation group health plan coverage is considered alternative group health plan coverage for purposes of COBRA. Therefore, if a Participant elects USERRA continuation coverage, COBRA continuation group health plan coverage shall not be available.

(d) Participants returning from military leave shall be reinstated upon re-employment, and any exclusion or waiting period shall not be imposed if such exclusion or waiting

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period would not have been imposed had the Participant's coverage not been terminated due to military leave. This paragraph shall not apply to illnesses or injuries determined by the Secretary of Veteran's Affairs or his or her representative to have been incurred in, or aggravated during, the performance of military service.

(e) In no event shall benefits available under this Plan during a period of USERRA qualified military leave be less generous than those benefits available during other comparable employer approved leave periods (e.g., family and medical leave).

7.9 COBRA.

(a) Legal Rights to Continuation Coverage Under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). The Employer, to the extent required by law, shall offer a Participant and/or a Spouse or dependent child who, as a result of a "qualifying event," becomes otherwise ineligible to participate in a group health plan, as defined in Section 607(l) of ERISA, under the Plan the opportunity to temporarily extend coverage under such group health plan at group rates. A domestic partner shall not be considered a Spouse for COBRA purposes and therefore shall not be entitled to COBRA continuation coverage unless otherwise required under applicable law. However, the Employer may, solely in its own discretion, and solely in the manner it determines, provide continuation coverage to domestic partners who are Plan beneficiaries.

(b) Qualifying Events.

(i) A Participant who loses group health plan coverage or for whom premium payments or contributions for coverage increase as a result of one of the following qualifying events, shall be eligible for COBRA continuation coverage.

(A) A reduction of the Participant's hours of employment;

(B) The Participant's voluntary or involuntary termination of employment for reasons other than gross misconduct; or

(C) Upon the Employer's bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is a retired employee.

(ii) A Spouse who loses group health plan coverage or for whom premium payments or contributions for coverage increase as a result of one of the following qualifying events, shall be eligible for COBRA continuation coverage.

(A) The Participant's voluntary or involuntary termination of employment for reasons other than gross misconduct, or reduction of hours of employment;

(B) The death of the Participant;

(C) The divorce or legal separation of the Participant and Spouse;

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(D) Enrollment in Medicare (Part A or B) by the Participant; or

(E) The Employer's bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is retired.

(iii) A Participant's dependent child who loses group health plan coverage or for whom premium payments or contributions for coverage increase as a result of one of the following events, shall be entitled to COBRA continuation coverage.

(A) The loss of Dependent status under the group health plan;

(B) The Participant's voluntary or involuntary termination for reasons other than gross misconduct, or the Participant's reduction of hours of employment;

(C) The death of the Participant;

(D) The divorce or legal separation of the Participant and Spouse;

(E) Enrollment in Medicare (Part A or B) by the Participant; or

(F) The Employer's bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is retired.

(c) Qualified Beneficiary. A Qualified Beneficiary is a Participant, Spouse, or dependent child who on the day before a qualifying event is covered under a group health plan available under the Plan. Qualified Beneficiary includes children born to, adopted by, or placed for adoption with the Participant during his or her COBRA continuation coverage period. Such child's coverage period shall be determined according to the date that the Participant's COBRA continuation coverage period began. A domestic partner is not a Qualified Beneficiary for COBRA purposes and therefore shall not be entitled to COBRA continuation coverage as described in this Article VII unless otherwise required under applicable law.

(d) Notices. A Qualified Beneficiary who wishes to receive COBRA continuation coverage as a result of divorce or legal separation must notify the Plan Administrator within 60 days after such divorce or legal separation. A Qualified Beneficiary who wishes to receive COBRA continuation coverage as a result of the loss of Dependent status under the group health plan available under the Plan must notify the Plan Administrator within 60 days of such loss of Dependent status.

The Qualified Beneficiary shall be notified of his or her right to elect continuation coverage and the cost to do so. Continuation coverage must be elected within 60 days after the later of the date coverage under the group health plan available under the Plan ceases or the date the Qualified Beneficiary is notified of the right to elect continuation coverage.

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If the Qualified Beneficiary does not elect continuation coverage, coverage under the group health plan available under the Plan shall cease. If the Qualified Beneficiary chooses continuation coverage, such group health plan shall provide coverage identical to that available to similarly situated active employees, including the opportunity to choose among options available during an open enrollment period.

(e) Cost. The Qualified Beneficiary must pay the full cost of such coverage to the Plan for a similarly situated active employee. The Plan may charge a 2% administrative fee. The COBRA premium may increase to 150% of the total premium during a disability extension as described in paragraph (f)(iv).

(f) Maximum Continuation Period.

(i) A Qualified Beneficiary who loses group health plan coverage available under the Plan as a result of the death of the Participant, the Participant's eligibility for Medicare, divorce, legal separation or loss of Dependent status under such group health plan and elects COBRA continuation coverage shall be entitled to receive up to 36 months of COBRA continuation coverage beginning on the date on which the qualifying event occurred.

(ii) A Qualified Beneficiary who loses group health plan coverage as a result of the Participant's termination of employment or reduction of hours and elects COBRA continuation coverage shall be entitled to receive up to 18 months of COBRA continuation coverage beginning on the date on which the qualifying event occurred. If a second qualifying event occurs during such 18-month period, the COBRA continuation coverage period may be extended by an additional 18 months for each Qualified Beneficiary (other than a covered Employee). The Qualified Beneficiary must notify the Plan Administrator within 60 days of a second qualifying event to receive the additional 18 months of continuation coverage. A second qualifying event is an event that occurs during the initial 18-month period that would have resulted in a loss of group health plan coverage for the Qualified Beneficiary in the absence of the first qualifying event. In no event, however, shall any Qualified Beneficiary's COBRA continuation coverage period exceed 36 months.

(iii) A Qualified Beneficiary (other than the Participant) who loses group health plan coverage as a result of the Participant’s termination of employment or reduction of hours and such event occurs within 18 months following the Participant’s enrollment in Medicare, shall be entitled to receive up to 36 months of COBRA continuation coverage beginning on the date the Participant enrolled in Medicare.

(iv) If a qualifying event occurs that is the Participant's termination of employment or reduction of hours, any Qualified Beneficiary who is deemed to have been disabled, as determined by the Social Security Administration, at any time during the first 60 days of COBRA continuation coverage shall be eligible to extend the COBRA continuation coverage period to 29 months. In the case of a child born to or adopted by a Participant during the Participant's COBRA continuation coverage period, such 60-day period will begin from the date of birth or placement of adoption. Such extension shall apply to the Qualified Beneficiary's covered family members. Such Qualified Beneficiary must notify the Plan Administrator of the disability in writing within 60 days of the date of the Social Security Administration determination and before the end of the 18-month continuation coverage period. A Qualified Beneficiary receiving extended COBRA continuation

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coverage due to disability must inform the Plan Administrator within 30 days of receiving a final determination that he or she is no longer disabled.

(v) In the case of a qualifying event that is the bankruptcy of the Employer, the maximum coverage period for a Qualified Beneficiary who is the retired covered employee ends on the date of the retired covered employee's death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse, or dependent child of the retired covered employee ends on the earlier of—(A) The date of the Qualified Beneficiary's death; or (B) The date that is 36 months after the death of the retired covered employee.

(g) Termination of COBRA Continuation Coverage. COBRA continuation coverage shall cease upon the occurrence of any of the following events:

(i) The Employer ceases to provide group health plan coverage to any of its employees;

(ii) The Qualified Beneficiary fails to pay the premium or required contribution within 30 days after its due date;

(iii) The Qualified Beneficiary becomes covered, after the date of the COBRA continuation coverage election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any preexisting condition of such Qualified Beneficiary (other than an exclusion or limitation that may be disregarded under the law);

(iv) The Qualified Beneficiary becomes enrolled in Medicare after the date of the COBRA continuation coverage election;

(v) The Qualified Beneficiary has extended COBRA continuation coverage due to a disability and is subsequently determined by the Social Security Administration to be no longer disabled;

(vi) The maximum required COBRA continuation coverage period expires; or

(vii) For cause, such as fraudulent claim submission, that would result in termination of coverage for a similarly situated active employee.

(h) Second Election Period. A Participant and his or her covered family members may be eligible to elect continuation coverage during a second election period if such Participant:

(i) is receiving trade adjustment assistance benefits under the Trade Act of 2002 (or would be eligible to receive trade adjustment assistance benefits but has not exhausted unemployment benefits);

(ii) lost health coverage due to termination of employment that resulted in eligibility for trade adjustment assistance benefits under the Trade Act of 2002; and

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(iii) did not elect COBRA continuation coverage during the initial COBRA election period.

The second election period is the 60-day period beginning on the first day of the month in which the Participant becomes eligible for such second election period, but only if the election is within the six-month period after the Participant initially lost coverage. COBRA continuation coverage begins on the first day of the second election period. Such coverage is not retroactive to the date the Participant initially lost coverage.

7.10 Genetic Information Nondiscrimination Act of 2008 ("GINA"). (a) Unless otherwise permitted, the Employer may not request or require any genetic information from an Employee or family member of the Employee.

(b) "Genetic information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

(c) The Employer shall not request any genetic information when requesting health-related information. However, with respect to any wellness program available under the Plan, the Employer may request, but may not require, an Employee to provide genetic information in accordance with Equal Employment Opportunity Commission regulations.

(d) The Employer will not request, require or purchase genetic information in violation of GINA. If the Employer intentionally or unintentionally obtains genetic information pertaining to an Employee or a family member of the Employee, the Employer will not use such genetic information in violation of GINA. Any genetic information received by the Employer that pertains to an Employee or a family member of the Employee, shall be maintained on forms and in medical files that are separate from personnel files, and shall be treated as confidential medical records.

7.11 Health-Related Factors. The group health plan will not discriminate against any participant or dependent in terms of eligibility to participate in the plan based on a health-related factor. In addition, benefits provided under the group health plan will be available to all similarly situated individuals. Any restriction on benefits will be applied uniformly to all similarly situated individuals and may not be directed at an individual based on a health-related factor. The group health plan may (i) limit or exclude benefits that are experimental or are not medically necessary and (ii) require an individual to satisfy a deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit, provided that all limits, exclusions, or cost-sharing requirements apply uniformly to all similarly situated individuals, and are not just directed at an individual based on a health-related factor.

7.12 Mental Health Parity Act. The group health plan must generally comply with the provisions of the Mental Health Parity and Addiction Equity Act of 2008, including that the group health plan's financial requirements (such as co-pays and deductibles) and treatment limitations

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(such as annual visit limits) that are applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

ARTICLE VIII

Amendment and Termination

8.1 Amendment. The Employer has the right to amend the Plan at any time, including the right to amend any of the Welfare Programs or to transfer any Welfare Program from the Plan into a separate, related plan, at the direction of an authorized officer of the Employer or an authorized designee.

8.2 Termination. The Employer has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Employer is not and shall not be under any obligation or liability whatsoever to maintain the Plan (or any Welfare Program) for any given length of time and may, in its sole and absolute discretion, discontinue or terminate the Plan, in whole or in part, at any time, including termination of any one or more of the Welfare Programs, at the direction of an authorized officer of the Employer or an authorized designee.

ARTICLE IX

Miscellaneous

9.1 Exclusive Benefit. This Plan has been established for the exclusive benefit of Participants, Spouses, Dependents or Beneficiaries, and except as otherwise provided herein, all contributions under the Plan may be used only for such purpose.

9.2 Non-Alienation of Benefits. No benefit, right or interest of any Participant, Spouse, Dependent or Beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law or, in the case of assignments, as permitted under the terms of a Welfare Program.

9.3 Limitation of Rights. Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed as to:

(a) give any person any legal or equitable right against the Employer (or Participating Employer) except as expressly provided herein or required by law, or

(b) create a contract of employment with any Employee, obligate the Employer (or Participating Employer) to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way.

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9.4 Governing Laws and Jurisdiction and Venue. The Plan shall be construed and enforced according to the laws of the state of Illinois to the extent not preempted by federal law which shall otherwise control. Exclusive jurisdiction and venue of all disputes arising out of or relating to this Plan or any of the Welfare Programs shall be in any court of appropriate jurisdiction in the state of Illinois.

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

9.6 Construction. The captions contained herein are inserted only as a matter of convenience and reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

9.7 Titles. The titles of the Articles and Sections hereof are included for convenience only and shall not be construed as part of the Plan or in any respect affecting or modifying its provisions. Such words in this Plan as "herein," "hereinafter," "hereof" and "hereunder" refer to this instrument as a whole and not merely to the subdivision in which said words appear.

9.8 Expenses. Subject to the terms of the Welfare Programs, any expenses incurred in the administration of the Plan shall be paid by the Plan and/or by the Employer, according to the Employer's determination.

ARTICLE X

Participating Employers

10.1 Adoption of the Plan. This Plan may be adopted by a Participating Employer, provided that such adoption is with the approval of the Employer. Such adoption shall be by resolution of the Participating Employer's governing body.

10.2 Administration. As a condition to adopting the Plan, and except as otherwise provided herein, each Participating Employer shall be deemed to have authorized the Plan Administrator to act for it in all matters arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Plan Administrator.

10.3 Termination of Participation. Each Participating Employer may cease to participate in the Plan or in any Welfare Program with respect to its Employees or former Employees by resolution of its governing body.

ARTICLE XI

Effective Date

The effective date of this Plan is January 01, 2025.

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* * * * *

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IN WITNESS WHEREOF, the Employer has caused this instrument to be duly executed in its name and on its behalf as of the date set forth below.

Watterson Environmental Group, LLC

Signed by:
Meechi Hoffman
196BBB685632437...

By: _____

Date: June 3, 2025 | 7:33 PDT

ATTEST:

_____

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APPENDIX A
WATTERSON ENVIRONMENTAL GROUP HEALTH AND WELFARE PLAN

WELFARE PROGRAMS

The following Welfare Programs shall be treated as part of the Plan pursuant to Section 2.15 and as defined in Section 2.19:

Welfare Programs
BCBS Medical Plan

Carrier's or Program Administrator's Name:	BCBS of IL
Contract Number:	276910
Address:	3500 Lacey Road Downers Grove, Illinois 60515
	8005481687 https://www.bcbsil.com/

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Kaiser Medical Plan

Carrier's or Program Administrator's Name:	Kaiser Permanente
Contract Number:	22218
	(800) 382-4661 https://healthy.kaiserpermanente.org/

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

MetLife Dental Plan

Carrier's or Program Administrator's Name:	MetLife
Contract Number:	5386983
	(800) 854-6011 http://www.metlife.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

MetLife Basic Life and AD&D Plan

Carrier's or Program Administrator's Name:	MetLife
Contract Number:	5386983
	(800) 854-6011 http://www.metlife.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

MetLife LTD Plan

Carrier's or Program Administrator's Name:	MetLife
Contract Number:	5386983

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(800) 854-6011
http://www.metlife.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

MetLife STD Plan
Carrier's or Program Administrator's Name: MetLife
Contract Number: 5386983

833-393-5433
metlife.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

MetLife Accident Plan
Carrier's or Program Administrator's Name: MetLife
Contract Number: 5386983

833-393-5433
metlife.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

MetLife Critical Illness Plan
Carrier's or Program Administrator's Name: MetLife
Contract Number: 5386983

833-393-5433
metlife.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

MetLife Hospital Indemnity Plan
Carrier's or Program Administrator's Name: MetLife
Contract Number: 5386983

833-393-5433
metlife.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

MetLife Voluntary Life and AD&D Plan
Carrier's or Program Administrator's Name: MetLife
Contract Number: 5386983

833-393-5433
metlife.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

MetLife EAP Plan
Carrier's or Program Administrator's Name: MetLife
Contract Number: 5386983

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833-393-5433
metlife.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

VSP Vision Plan

Carrier's or Program Administrator's Name: VSP
Contract Number: 40157128
Address: 3333 Quality Drive
Rancho Cordova, California 95670

(800) 877-7195
http://www.vsp.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Premium Conversion Plan

Carrier's or Program Administrator's Name: Watterson Environmental Group, LLC
Address: 1700 E Golf Rd, Suite 500
Schaumburg, IL 60173

(847) 521-3134

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

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APPENDIX B
WATTERSON ENVIRONMENTAL GROUP HEALTH AND WELFARE PLAN

PARTICIPATING EMPLOYERS

In addition to Watterson Environmental Group, LLC, the following Participating Employers have adopted the Plan pursuant to Section 10.1:

J.R. Johnson, LLC

There are no other employers participating in the Plan.