SMITHS GROUP SERVICES CORPORATION WELFARE PLAN

Amended and Restated
Effective as of August 1, 2023 (except as otherwise noted)

SMITHS GROUP SERVICES CORPORATION WELFARE PLAN

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ARTICLE I FOREWORD

The Smiths Group Services Corporation Welfare Plan ("Plan") is sponsored by Smiths Group Services Corporation ("Smiths Group") for the benefit of its Eligible Employees and Retirees, and the Eligible Employees and Retirees of the subsidiaries and divisions designated by Smiths Group as participating employers. The Plan is intended to provide health care and other welfare benefits to Eligible Employees and Retirees, and, in certain cases, their eligible Dependents. The Plan is comprised of various Separate Programs and is designed to operate in conjunction with the cafeteria plan sponsored by Smiths Group, which is set forth in a separate document, but is part of this Plan. For purposes of Code section 105(h), this Plan may include a number of separate Self-Insured Health Plans. In addition, the Plan may include one or more Insured Plans and HMOs, each benefiting Eligible Employees, Retirees or another group or groups as designated by Smiths Group.

This Plan was first established effective as of October 1, 1985 and has been amended from time to time. The Plan is intended to be a single plan, known as plan number 501, for reporting and disclosure purposes under ERISA and includes component Separate Programs which are insured and self-insured. The benefits provided under each of the Separate Programs are described in the applicable SPDs which are hereby incorporated by reference, as they may be revised from time to time, without the need for a formal amendment to the Plan.

The Plan is amended and restated herein, generally effective August 1, 2023, unless otherwise indicated herein.

ARTICLE II DEFINITIONS

2.1 Definitions:

Where the following underlined words and phrases appear in this Plan, they shall have the meaning set forth below, unless a different meaning is plainly required by the context.

(a) ACA: The Patient Protection and Affordable Care Act of 2010, as amended from time to time, including by the Health Care and Education Reconciliation Act of 2010, and any regulatory, sub-regulatory or other official guidance issued pursuant thereto.

(b) Approved Severance Program: A severance program (or similar arrangement) of the Employer (if any) or an employment or termination agreement between the Employer and a Participant providing for severance pay and/or a general release of claims against the Employer.

(c) Cafeteria Plan: The Smiths Group Services Corporation Flexible Benefits Plan, as may be amended from time to time.

(d) COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and any regulatory, sub-regulatory or other official guidance issued pursuant thereto.

(e) Code: The Internal Revenue Code of 1986, as amended from time to time, and any regulatory, sub-regulatory or other official guidance issued pursuant thereto.

(f) Company: Smiths Group Services Corporation, or its successor or successors.

(g) Contract Administrator: The person, company or party identified in the SPD, or in a subsequent agreement entered into by the Company, as the contract or claims administrator (or as having any of the powers authorized by Article VI for a Contract Administrator) for the applicable Separate Programs, as designated by the Company. The Contract Administrator may include an Insurer with respect to an Insured Plan. If there is no Contract Administrator designated (either in the SPD or a subsequent agreement) for the applicable Separate Program, the Plan Administrator (or its delegate) will instead act on behalf of the Plan with respect to those powers and duties that are assigned to the Contract Administrator under the other terms of this Plan. The Company may designate different parties to serve as the Contract Administrator for different Employers, different Separate Programs, different categories of benefits under one or more Separate Programs and different purposes under the Plan.

(h) Coverage Period: The period during which the terms and provisions of a Separate Program are in effect for any eligible class of Employees or Retirees, which is the Plan Year or such other period set forth in the applicable SPD.

(i) Disabled: A Participant shall be considered to be "Disabled" if the individual (1) is determined to be disabled under a plan sponsored by the Company which provides short-term disability benefits, and (2) is receiving (before any offsets or reductions are applied) disability benefits from such plan. A Participant shall no longer be "Disabled" for purposes of this Plan when the Participant fails to satisfy the prior sentence.

(j) Dependent: With respect to a Separate Program, a Participant's legal spouse, domestic partner, child or other individual, each of whom satisfy the dependent eligibility requirements set forth in the SPD of the Separate Program that is determined to be applicable to the Participant, and in the case of an Insured Plan, the applicable insured contract.

(k) EAP: The Separate Program of employee assistance program benefits.

(l) Eligible Employee: An Employee who is eligible for the Plan in accordance with the provisions of Section 3.1.

(m) Employee: Any person who is (1) an employee of an Employer, provided such person is classified as an active employee by the Employer, (2) an Employee or former Employee of an Employer who becomes Disabled at a time when he or she is classified as an active employee of an Employer, (3) a former Employee (other than a Retiree or a former employee who is Disabled) to the extent the applicable SPD provides for coverage after termination of employment, and (4) any former employee of an Employer who is receiving compensation through an Approved Severance Program (but only to the extent the Approved Severance Program provides coverage under a Separate Program). When used in the preceding sentence, the term "employee" shall mean that the individual is shown as an employee in the Employer's personnel records and on the Employer's payroll and has FICA taxes withheld by the Employer. Pursuant to rules adopted by each Employer (and applied in a similar manner to similarly situated employees), an individual may also be considered an Employee while on an authorized leave of absence from his Employer; provided that participation in this Plan or a Separate Program is specifically authorized during such leave of absence. A former employee may be considered an Employee only to the extent the SPD provides for the extension of coverage following termination of employment, or to the extent necessary to provide individuals whose coverage has ceased with payment for claims incurred while still covered. An Employee must have a primary place of employment in the United States (i.e., the 50 states and the District of Columbia. A former Employee must have had his primary place of employment in the United States with an Employer immediately prior to becoming a former Employee.

(n) Employer: The Company and any other member of the Smiths Group Organization which has been authorized by the Company to participate and is participating in this Plan. An entity or division shall only be an Employer hereunder for the period of time that it is authorized to participate in this Plan.

(o) ERISA: Public Law 93-406, the Employee Retirement Income Security Act of 1974, as amended from time to time, and any regulatory, sub-regulatory or other official guidance issued pursuant thereto.

(p) Essential Health Benefits: For each HIPAA Separate Program, a listing of core medical benefits set forth in ACA section 1302(b)(1).

(q) Fiduciaries:

(1) The named fiduciaries, as defined in section 402 of ERISA, who shall be the Company (but solely with respect to its power to designate other Fiduciaries) and the Plan Administrator;

(2) Each Contract Administrator, unless (i) the Plan Administrator and the Contract Administrator have agreed in writing that the Contract Administrator shall not be a fiduciary, or (ii) the Plan Administrator has assumed complete fiduciary responsibility with respect to the Separate Program that is administered by the Contract Administrator; and

(3) Other parties who are designated as fiduciaries as defined in section 3(21) of ERISA by the named fiduciaries, in accordance with the terms of the Plan;

provided that a party shall be a Fiduciary only with respect to its specific responsibilities in connection with the Plan.

(r) HCSA: The Separate Program that reimburses Participants for qualifying health care expenses and that constitutes a flexible spending arrangement within the meaning of Code Section 106(c)(2). The HCSA is part of this Plan but is described in a separate document.

(s) HIPAA Separate Program: Each Separate Program under this Plan that is a group health plan other than the following Separate Programs:

(1) Any Separate Program providing limited-scope dental benefits pursuant to Code Section 9832(c)(2)(A) and Treas. Reg. Section 54.9831-1(c)(3);

(2) Any Separate Program providing limited-scope vision benefits pursuant to Code Section 9832(c)(2)(A) and Treas. Reg. Section 54.9831-1(c)(3);

(3) The HCSA;

(4) The EAP; and

(5) Any other Separate Program determined by the Plan Administrator to be exempt under Code Sections 9831 and 9832 and related guidance issued pursuant thereto.

(t) HMO: A health maintenance organization, including any organized systems of care (OSCs) or "preferred medical plans," which is a group of doctors, hospitals or other health care Providers who agree to provide medical services for a fixed cost to members of the HMO subject to other terms and conditions applicable to individuals who are members.

(u) Insured Plan: A plan that provides health or other welfare benefits on a basis which is considered insurance under a contract issued in accordance with applicable state insurance laws and that is designated by the Company as a Separate Program.

(v) Insurer: Each insurance company which guarantees and pays each of the Insured Plan benefits pursuant to its applicable contract with or insurance policy issued to the Company.

(w) Participant: Any Eligible Employee or Retiree who is eligible for and enrolled in one or more Separate Programs offered under the Plan.

(x) PHSA: The Public Health Service Act, as amended by the ACA, plus any regulatory, sub-regulatory and other guidance issued pursuant thereto.

(y) Plan: The Smiths Group Services Corporation Welfare Plan, as set forth herein and as amended from time to time. The Plan includes all of the Separate Programs (and the SPDs of the Separate Programs).

(z) Plan Administrator: The Plan Administrator shall be the Company or such other entity, individual or committee of individuals, as appointed by the Company (or its delegate) to serve as the Plan Administrator. The Plan Administrator has the discretionary authority to administer the Plan as provided in Article VI (except with respect to those areas of responsibility allocated solely to a Contract Administrator, Insurer or other appropriate party under Article VI). If the Plan Administrator delegates some or all of its duties pursuant to Article VI, references in the Plan to the Plan Administrator shall also refer to its delegate to the extent of any such delegation.

(aa) Plan Year: The 12 consecutive month period commencing on each August 1 and ending on each subsequent July 31.

(bb) Qualified Medical Child Support Order: Any judgment, decree, or order complying with Section 609 of ERISA that creates or recognizes the existence of an alternate recipient's right to receive health benefits under the Plan.

(cc) Retiree: An Employee who has incurred a Retirement and is eligible for the Plan in accordance with the provisions of Section 3.1.

(dd) Retirement: Termination of active employment with an Employer at a time when the Plan Administrator determines that the individual satisfies the age, service, employment classification and any other criteria specified by the Plan Administrator for the purpose of eligibility for retiree coverage in the SPD applicable to that individual, if any.

(ee) SBC: A Summary of Benefits and Coverage, as set forth by Section 2715 of the PHSA, as incorporated by reference into ERISA under ERISA Section 715(a)(1).

(ff) Self-Insured Health Plan: A plan that provides medical and other health care coverage on a basis that is considered self-insurance pursuant to Code Section 105(h).

(gg) Separate Program: A Self-Insured Health Plan, an Insured Plan or any other program which is determined by the Plan Administrator to provide benefits under this Plan and to be a Separate Program hereunder. Not all Separate Programs are available to all Eligible Employees or Retirees. The Separate Programs are described in more detail in the applicable SPD, as amended from time to time, which is by this reference made a part hereof. Certain Separate Programs are described in Appendices or separate documents and such Appendices are a part of this Plan document and subject to the terms hereof. Appendix Article SP sets forth the available programs and may be amended at any time without a formal amendment to the Plan.

(hh) Service Date: The date that the service was rendered or the supply was provided to the Participant or Dependent under the terms of this Plan and the applicable Separate Program. For purposes of the Separate Programs that provide prescription drug benefits, the Service Date shall be the date that the prescription was filled by the pharmacy or other approved entity.

(ii) Smiths Group Organization: The controlled group of corporations of which the Company is a member, as defined in Code Section 414(b) and (c) and the regulations issued thereunder. An entity shall be considered a member of the Smiths Group Organization only during the period it is one of the group of organizations described in the preceding sentence.

(jj) SPD: A summary plan description, including any related summary of material modifications or summary of material reductions to a summary plan description, describing one or more of the Separate Programs, as designated by the Plan Administrator. Only those portions of an SPD that relate to a Separate Program are incorporated herein pursuant to an incorporating reference in this Plan to the SPD. With respect to any Employee, Retiree or Dependent, a reference herein to an SPD shall refer to the SPD which is determined by the Plan Administrator to be applicable to the individual for the applicable Coverage Period or Plan Year. Where the Plan Administrator determines that a SPD cannot be located, the Plan Administrator may consider other documents (including Recognized Enrollment Materials, as defined in Section 9.6(b)) to be the SPD for the purpose of determining the eligibility, benefits and other terms and conditions of the Separate Program.

(kk) State Plan: A State plan for medical assistance approved under Title XIX of the Social Security Act.

(ll) Third Party: Any individual, entity, person or party, directly or indirectly, responsible for causing a Participant's or Dependent's illness, injury or condition or responsible for making any payment to or on behalf of a Participant or Dependent due to the Participant's or Dependent's illness, injury or condition. A Third Party shall include any applicable insurance coverage of the Participant, Dependent, individual, entity, person or party, including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, no-fault automobile insurance coverage, personal umbrella coverage, workers' compensation or similar coverage, homeowner's or renter's insurance coverage, and any first-party insurance coverage. However, a Third Party shall not include any individual or supplementary insurance policy or coverage classified as an individual cancer, individual specific disease or individual hospital indemnity policy (e.g., individual policies sold by AFLAC).

(mm) Third Party Proceeds: A dollar amount paid or owed by or on behalf of a Third Party (whether by settlement, judgment, compromise, insurance or otherwise).

ARTICLE III ELIGIBILITY AND PARTICIPATION

3.1 Eligibility:

(a) General. An individual is eligible to participate in this Plan (subject to completion of any applicable waiting period) if –

(1) The individual is an Employee who is in an employment classification designated in the eligibility provisions an applicable SPD as eligible to participate in one or more Separate Programs; or

(2) The individual is a Retiree who is in a classification designated in the eligibility provisions of an applicable SPD as eligible to participate in one or more Separate Programs; or

(3) The individual is a former Employee who is in a classification designated in the eligibility provisions of an Approved Severance Program of an Employer under Section 3.2(e)(1) as eligible to participate in one or more Separate Programs.

If an Eligible Employee is on an authorized leave of absence from an Employer, he or she shall be eligible to participate in this Plan only to the extent that his or her authorized leave or the applicable provisions of an SPD specifically provide for eligibility or participation in one or more Separate Programs.

In general, if an Eligible Employee is covered by a collective bargaining agreement, he or she must also meet the eligibility criteria set forth in such collective bargaining agreement, as determined by the Plan Administrator in its sole discretion.

(b) Ineligible Individuals. The following individuals are not eligible to participate in the Plan:

(1) Any Employee whose terms and conditions of employment are determined by a collective bargaining agreement with a union representing such individuals and with respect to whom inclusion in this Plan has not been specifically provided for in such collective bargaining agreement;

(2) Any Employee who is classified by an Employer in accordance with its usual practices as part-time working less than the required minimum hours except as otherwise expressly provided in the SPD.

(3) Any Employee who is classified by an Employer in accordance with its usual practices as temporary, seasonal or an intern, except as otherwise expressly provided in the SPD;

(4) Any person who is a leased employee of an Employer within the meaning of Code section 414(n), unless the leasing organization is another Employer (or a subsidiary or affiliate of another Employer) and has authorized such person's eligibility in the Plan;

(5) Any person who is designated by the Employer as an independent contractor or as an employee of a person with whom the Employer has entered into a consulting or services agreement;

(6) Any non-resident alien receiving no U.S. source earned income; and

(7) Any other individual who is designated by an Employer as coming within a classification that is ineligible for participation in this Plan.

(c) Acquisitions and Divestitures:

(1) General. A written agreement (an "Agreement") between an Employer and a party that is not part of the Smiths Group Organization (at the time the agreement is entered into) regarding the Acquisition or Divestiture of one or more business units, divisions, corporations, companies, or subsidiaries (each a "Business") may provide for the termination or commencement of the participation of Employees in this Plan or any Separate Program. Approval and execution of an Agreement by one or more Employers is approval by the Company of the designation of Separate Program eligibility that may be contained in such Agreement and shall be treated as an amendment to this Plan pursuant to Article VII. Unless otherwise specifically provided in such Agreement:

(i) Each Employee of a Business that is Divested will cease being eligible for this Plan (and the Separate Programs herein) upon the effective date of such Divestiture, and

(ii) No Employee of a Business (or any other individual associated with such Business) that is Acquired shall be eligible for this Plan or any Separate Program hereunder unless and until such eligibility is formally provided by either a Plan amendment or a written designation in accordance with paragraph (2) below.

(2) Written Designations. The Plan Administrator may designate in writing eligibility in one or more Separate Programs hereunder for any Employees of an Acquired Business who are otherwise eligible hereunder. Such designation may be in a separate document or may be addressed in one or more applicable SPDs that are distributed to the affected Employees.

(3) Definitions. For purposes of this subsection (c), the following capitalized terms shall have the following meanings:

(i) Acquisition: The purchase or other acquisition of a Business, or other merger, combination or reorganization that results in the acquisition of a Business. The related term, "Acquired," shall mean the act of an Acquisition.

(ii) Divestiture: The sale or other divestiture of a Business, or other spin-off, initial public offering or other reorganization that results in the divestiture of a Business. The related term, "Divested," shall mean the act of a Divestiture.

(d) Reclassification: This subsection applies to any individual classified by the Employer as a leased employee, independent contractor or coming within a non-Employee, non-Dependent or other ineligible designation. If any such individual is thereafter required by the Internal Revenue Service, Department of Labor or other governmental agency, or by any court or other tribunal to be classified as an Employee, Dependent or otherwise in an eligible classification for this Plan, such individual shall not be eligible to participate in this Plan unless and until the time the individual is designated by the Plan Administrator as an Eligible Employee, eligible Dependent or other eligible individual. Such designation shall only provide for eligibility prospectively from the time it is made, even if the decision or requirement applies retroactively.

3.2 Participation:

(a) Commencement of Participation: An Eligible Employee or Retiree begins participation in the Plan on the first day of participation in any Separate Program. An Eligible Employee or Retiree begins participation in a Separate Program on one of the following dates:

(1) An Eligible Employee who qualifies for participation in a Separate Program under the eligibility provisions of an applicable SPD, and who meets any requirements for such Separate Program (including any applicable waiting period, service requirement, enrollment or contribution requirement) begins participation on the day his enrollment is considered effective by the Plan Administrator (or in the case of a Separate Program for which no enrollment applies, the day he first can actively participate in accordance with the terms of the SPD and any requirements of the Plan Administrator). Enrollment in a Separate Program which is a qualified benefit under Code Section 125 and the Cafeteria Plan must also satisfy the requirements of the Cafeteria Plan.

(2) A Retiree who qualifies for participation in a Separate Program under the eligibility provisions of an applicable SPD, and who meets any requirements for such Separate Program (including any applicable date of hire, date of Retirement, age, service, enrollment contribution or other requirement) begins participation on the day his enrollment is considered effective by the Plan Administrator (or in the case of a Separate Program for which no enrollment applies, the day he first can actively participate in accordance with the terms of the SPD and any requirements of the Plan Administrator).

(3) A Dependent for whom a Participant has made an election for coverage under a Separate Program begins participation on the first day the Dependent can actively participate in accordance with the terms of the SPD; provided, that unless otherwise expressly provided in the SPD, a Dependent may not begin participation in a Separate Program prior to the participation of the Eligible Employee through whom the Dependent is entitled to coverage.

(4) An Eligible Employee or Retiree may begin participation in this Plan by electing coverage under a Separate Program that is an HMO only if the Plan offers the HMO to the group or class of Employees or Retirees of which the individual is a member.

(b) Terms of Participation: After enrolling in a Separate Program, a Participant's and/or Dependent's continued participation in any Separate Program under the Plan is subject to submission of a proper election of benefits, including any necessary reenrollment elections, as directed by the Plan Administrator, payment of any required contributions and cooperation in accordance with the terms of the Plan, including Sections 4.4 and 4.8, and the terms of the Cafeteria Plan. Under rules adopted from time to time for a Separate Program, the Plan Administrator may treat the failure to respond to an enrollment or reenrollment opportunity as expressing an intent to be enrolled in a particular way. A Dependent may not be enrolled except during an enrollment period, as directed by the Plan Administrator, that specifically permits the enrollment of such class of Dependents.

(c) Termination of Participation for Participants: A Participant shall continue to participate in the Plan until he no longer participates in any Separate Program or, if earlier, until the Plan is terminated. A Participant shall continue to participate in a Separate Program until the earliest of the following dates:

(1) The date the Participant ceases participation in the Separate Program in accordance with the applicable provisions of the SPD, the Cafeteria Plan or any other written

notice from the Plan to one or more applicable groups of Participants, including ceasing participation due to death, retirement, or other termination of employment;

(2) The date the Participant fails to pay any required premiums or contributions after any applicable grace period which the Plan Administrator applies for this purpose (in which case termination shall be made effective as the end of the day through which contributions were paid, unless the Plan Administrator determines that the facts and circumstances warrant a termination effective as of a different day);

(3) The date the Participant ceases to satisfy the eligibility criteria of Section 3.1 or the applicable Separate Program;

(4) The date the Participant fails to comply with subsection (b) above;

(5) The date the Participant fails to cooperate fully with the Plan Administrator, Insurer or Contract Administrator with respect to the administration of the Plan or a Separate Program, including failing to provide requested information;

(6) The date the Plan Administrator terminates the Participant's participation in the Plan pursuant to Section 3.2(h) or Sections 4.4 or 4.8;

(7) The date as of which the Plan is amended to terminate the coverage of the Participant with respect to such Separate Program or the Plan;

(8) The date on which the Participant's Employer (or former Employer, with respect to Retirees) ceases to participate in the Plan; or

(9) The date as of which the Separate Program or the Plan is terminated.

Notwithstanding paragraph (1) above, a Participant may continue to participate in a Separate Program to the extent provided under Section 3.2(e).

(d) Termination of Participation for Dependents: A Dependent shall terminate participation in the Plan or a Separate Program at the same time as the Participant through whom the Dependent participates, except as follows:

(1) A Dependent's coverage terminates prior to the related Participant's coverage when:

(i) The Dependent ceases to meet the Dependent eligibility criteria under the Separate Program (as provided in the applicable SPD);

(ii) The Participant removes the Dependent from coverage at any enrollment or disenrollment opportunity;

(iii) The Separate Program ceases to cover the individual as a Dependent (including through amendment or termination of the Separate Program);

(iv) The date the Dependent fails to cooperate fully with the Plan Administrator, Insurer or Contract Administrator with respect to the administration of benefits;

(v) The date the Dependent fails to comply with subsection (b) above; or

(vi) The date the Plan Administrator terminates his or her participation in the Plan pursuant to Section 3.2(h) or Sections 4.4 or 4.8.

(2) A Dependent's coverage may terminate after the related Participant's coverage to the extent the Dependent qualifies for extended coverage for a former Participant's Dependents (or former Dependents) if and to the extent provided for in the SPD. If a Dependent's coverage is extended, the Dependent's coverage shall terminate for any of the reasons that would cause a Participant's coverage to terminate or for any of the reasons specified in the applicable SPD.

(e) Extended Participation:

(1) Approved Severance Program: To the extent provided in an Approved Severance Program, a Participant who qualifies for participation in such Approved Severance Program may be covered under one or more Separate Programs beyond the date such Participant would have terminated participation, but only as described in the applicable provisions of the Approved Severance Program.

(2) Approved Leave of Absence: A Participant who takes a leave of absence approved by his or her Employer shall be eligible to participate in this Plan to the extent provided in the SPD of the Separate Program applicable to the Participant and the Cafeteria Plan; provided, however, once the Participant is no longer on an approved leave of absence, his or her participation in the Separate Program shall terminate (unless the individual returns to active employment with an Employer as an Eligible Employee). While a Participant is on an approved leave of absence and is participating in this Plan, his or her participation shall be subject to the rules, procedures and limitations set forth in the SPD of the Separate Program that applies to the Participant and in the Cafeteria Plan, and the Participant must continue to satisfy all requirements for such coverage, including payment of any required contributions.

(f) Rehired Employees: All former Employees who have previously terminated employment or retired begin participation as any other newly hired Employee, unless otherwise specifically provided in the applicable SPD.

(g) COBRA Coverage: To the extent required by law, an individual who is eligible for COBRA coverage and who properly elects and maintains COBRA coverage in accordance with the applicable Separate Program shall participate in the Plan.

(h) Termination of Participation for Certain Acts: Subject to the provisions of Section 3.5 and, with respect to an Insured Plan, the applicable insurance policy, the Plan Administrator may terminate a Participant's and/or Dependent's participation in this Plan if the Plan Administrator determines that the Participant and/or Dependent has engaged in any of the following activities:

(1) Filing (or attempting to file) false, misleading or fraudulent claims for Plan benefits;

(2) Enrolling (or attempting to enroll) an individual as a Dependent by providing false misleading or fraudulent documentation or information regarding the individual's status as a Dependent;

(3) Failing to timely provide the Employer, the Plan, the Plan Administrator, or the Contract Administrator (or their representative) with documentation or information that an individual no longer qualifies as a Dependent under the terms of the Plan;

(4) Allowing any individual who is not properly enrolled in the Plan to use or have access to the Participant's or Dependent's identification card for a Separate Program; or

(5) Participating in any other practices that are determined by the Plan Administrator to be an abuse or violation of the Plan's rules.

The Plan Administrator shall have the sole and exclusive authority to determine, in its discretion, whether a Participant or Dependent has committed or participated in any of the actions described above, and whether to terminate such Participant's or Dependent's participation in this Plan as a result. Any termination of a Participant's or Dependent's participation under this subsection shall be for the period specified by the Plan Administrator which may be permanent based on the facts and circumstances. All such determinations may be based on any information, documentation or other evidence that the Plan Administrator determines is relevant and credible. While the Plan Administrator is investigating whether a Participant or Dependent has violated this subsection, the Plan Administrator shall have the authority to suspend Plan participation and payments of Plan benefits, until such time as the Plan Administrator makes its determination, at which time participation and benefits shall either terminate in accordance with this subsection or recommence, either retroactively or prospectively, as determined by the Plan Administrator.

In addition, for purposes of paragraphs (3) and (4) the Plan Administrator may require the Participant and/or the Dependent (i) to repay to the Plan the total amount of the Plan benefits for all Plan Years that the Plan paid to or on behalf of the improperly enrolled Dependent, or (ii) to pay to the Plan the total value of the Plan coverage (minus what the Participant or Dependent has already paid as a Participant or Dependent contribution) for all Plan Years that the Dependent was improperly enrolled.

For purposes of this subsection, the term, "Dependent" shall include any individual who is or has been enrolled in the Plan as a Dependent, regardless of whether such individual satisfies the actual requirements to be a Dependent under the Plan.

Any determinations made under this subsection are subject to the claims procedures of Sections 6.3 or 6.4, as applicable.

(i) Federal Leave Laws: In no event shall an individual's participation and enrollment rights and any of the other benefits under this Plan be less than as required by the Family and Medical Leave Act of 1993 and the Uniformed Services Employment and Reemployment Rights Act of 1994.

(j) Limited Participation: An Eligible Employee or Retiree and his or her Dependents only participate in this Plan to the extent that each such individual is eligible for and participates in one or more Separate Programs under this Plan pursuant to Section 3.1 and this Section 3.2. An Eligible Employee or Retiree and his or her Dependents may only participate in a Separate Program to the extent that this Plan document provides for such eligibility in the Separate Program and the applicable SPD of the Separate Program also provides for such eligibility. It is clearly contemplated that eligibility for certain Separate Programs is only available to certain Eligible Employees or Retirees and their Dependents as provided in the SPD applicable to the Separate Program.

(k) Limitation on Retiree Participation: Except as otherwise expressly provided in the SPD, an Employee who has incurred a Retirement and is eligible for coverage as a Retiree must elect

to commence such coverage in accordance with the terms and conditions of the applicable Retiree Separate Program. In addition, as designated by the Plan Administrator for one or more Separate Programs or groups of Retirees, if a Retiree drops coverage under this Plan or fails to elect Retiree coverage when it is first available, the Plan Administrator may, in its discretion,

(1) Permanently exclude the Retiree from participation in this Plan;

(2) Permit the Retiree to enroll or re-enroll in the Plan upon a change in status or at such other time as the Plan Administrator may apply for this purpose; or

(3) Subject the Retiree to any other participation or coverage rule in effect under a Separate Program for this purpose.

The Plan Administrator shall treat similarly-situated Retirees the same for purposes of this subsection. The designated rules for purposes of this subsection may be contained in the applicable SPDs of the Separate Programs from time to time.

(l) Provision of Benefits Without Regard to Medicaid Eligibility: When enrolling an Eligible Employee, Retiree or Dependent, or when determining a Participant's benefits under the Plan, the Plan shall not take into account whether the individual is eligible for or is provided medical assistance under Medicaid except as permitted under applicable law.

3.3 Special Enrollment Rights.

(a) HIPAA Special Enrollment Rights. Each HIPAA Separate Program shall provide each Eligible Employee, Participant and any other applicable individual any and all of the special enrollment rights to the extent required by Code Section 9801(f).

(b) Non-HIPAA Separate Programs. The Plan Administrator reserves the right to provide special enrollment rights similar to those set forth in Section 3.3(a) with respect to Separate Programs that are not HIPAA Separate Programs (e.g., a dental Separate Program). Any such special enrollment rights shall be set forth in the SPD for the applicable Separate Program and may be revised and/or terminated at any time.

3.4 GINA Enrollment Rules:

Each HIPAA Separate Program shall not:

(a) Request, require or purchase genetic information (as defined in Treas. Reg. Section 54.9802-3T(a)) with respect to any Eligible Employee, Participant, or Dependent prior to such individual's enrollment in the HIPAA Separate Program or in connection with such enrollment in violation of Treas. Reg. Section 54.9802-3T(d)(2)); or

(b) Request or require an Eligible Employee, Participant or Dependent to undergo a genetic test (as defined in Treas. Reg. Section 54.9802-3T(a)) in violation of Treas. Reg. Section 54.9802-3T(c).

3.5 Rescission of HIPAA Separate Program Coverage.

(a) Prohibition on Rescissions. Notwithstanding the termination provisions of Section 3.2, the Plan shall not rescind coverage under a HIPAA Separate Program for a Participant or

Dependent, unless the Participant or Dependent performs an act, practice, or omission that constitutes "fraud" or unless the Participant or Dependent makes an intentional misrepresentation of a material fact with respect to the HIPAA Separate Program coverage and only as permitted under the ACA. For this purpose, "fraud" shall mean the actions described in Section 3.2(h) as applied to the HIPAA Separate Program. If coverage may be rescinded under the foregoing provisions, the Plan Administrator shall provide the Participant or Dependent with at least 30 days advance written notice of such rescission. A rescission is subject to the claims procedures set forth in Section 6.3.

(b) Meaning of Rescission. For purposes of subsection (a), a rescission of coverage under a HIPAA Separate Program is a cancellation or discontinuance of such coverage that has retroactive effect except to the extent applicable law and guidance allows such cancellation or discontinuance of coverage not to be treated as a rescission. For example, a cancellation or discontinuance of coverage is not a rescission (and not subject to this Section 3.5) if:

(1) The Participant or Dependent voluntarily requests such cancellation or discontinuance with a retroactive effective date;

(2) The cancellation or discontinuance of coverage has only prospective effect;

(3) The cancellation or discontinuance of coverage is attributable to a failure to timely pay required premiums or contributions for such coverage; or

(4) The cancellation or discontinuance of coverage results from a Participant's termination of employment from an Employer.

ARTICLE IV BENEFITS

4.1 Benefits Provided Under the Plan.

(a) General. This Plan provides benefits through Separate Programs that generally include one or more coverages for certain welfare benefits, such as medical, dental, prescription drug, vision, life, disability, accidental death & dismemberment, voluntary supplemental health and legal, and such other benefits which may be added from time to time. The Insured Plans and HMOs included in this Plan are subject to the Plan's eligibility rules, requirements and procedures. The Plan Administrator determines Employee, Retiree and Dependent eligibility and enrollment for all Separate Programs, including Insured Plans, based on the eligibility rules provided herein. However, for Insured Plans or HMOs, non-eligibility determinations (such as benefit determinations and evidence of insurability) are made by the Insurer or HMO in accordance with its rules without other application of this Plan. Separate Programs that are Insured Plans may allow a Participant to convert to an individual policy or transfer ownership of a policy upon the occurrence of certain events. Once a conversion or transfer occurs, such policies are not part of the applicable Separate Program or this Plan.

(b) SPDs. Each Separate Program's benefits for a Participant and, if applicable, his Dependents are set forth in the SPD for the Separate Program that the Plan Administrator determines is applicable to that Participant, as the SPD may be revised from time to time. The benefits and coverage of a Separate Program that is an Insured Plan or HMO are available only if the Plan Administrator has determined that the Eligible Employee, Retiree and/or Dependent is eligible for the Insured Plan or HMO. The SPDs incorporated herein by reference are set forth from time to time in the Appendix or are recognized for incorporation by the Plan Administrator.

(c) COBRA. To the extent required by law and as set forth in the applicable SPD, COBRA coverage is provided with respect to each applicable Separate Program that is a group health plan.

(d) Limited Assignment of Payments. To the extent that a payment or reimbursement is payable by or from a Separate Program –

(1) Only the receipt of the payment or reimbursement may be assigned to a provider by the Participant or Dependent to the extent allowed by the rules and conditions of the Contract Administrator;

(2) The payment or reimbursement shall be paid pursuant to any applicable rules and conditions established by the applicable Contract Administrator; and

(3) The payment or reimbursement shall be paid to the provider that rendered the services or to the Participant, in the discretion of the applicable Contract Administrator.

Even though a Participant or Dependent may be permitted to assign the receipt of a payment or reimbursement from a Separate Program to a provider and even though a Contract Administrator may pay a provider directly for payments or reimbursements from a Separate Program, in no event shall any such assignment or the receipt of a payment or reimbursement by a provider make the provider a "participant" or "beneficiary" of the Plan within the meaning of ERISA. In addition, a direct payment or reimbursement by a Contract Administrator to a provider pursuant to this subsection shall not waive the application of subsections (e), (f) and (g).

(e) No Assignment of Plan Benefits. Separate and apart from assignments of payments and reimbursements under subsection (d) above, neither a Participant nor any Dependent shall have the power or authority to assign any benefits under a Separate Program or the Plan to any individual or entity (including a provider), and any such purported assignment of benefits shall be null and void.

(f) No Assignments of Plan Rights. Any actual or potential rights that a Participant or a Dependent has or may have under a Separate Program or this Plan (including the right to file an administrative claim or appeal and the right to sue after exhausting the administrative procedures) are personal to each Participant and Dependent, and shall not be subject in any manner to transfer or assignment to any other person or entity (including a provider). Any attempt to transfer or assign any such rights shall be null and void.

(g) Documents and Agreements Not Binding on Plan. Any agreement, assignment or other document executed by and between a provider and a Participant or Dependent (or executed by parties that include a provider and a Participant or Dependent, but that do not include the Plan Administrator or the Company) –

(1) Shall not be binding on and shall have no legal effect whatsoever on any Separate Program or the Plan, and

(2) Shall not alter or have any legal effect whatsoever on any terms, conditions or requirements of any Separate Program or the Plan.

(h) Wellness. One or more HIPAA Separate Programs may provide various wellness benefits, including health risk assessments, screenings, smoking cessation programs and disease management programs, for one or more groups of Participants and/or Dependents (the "Wellness Benefits"). The specific Wellness Benefits and the groups of Participants and/or Dependents who are eligible for such Wellness Benefits are set forth in the applicable SPD. If included, the Company provides Wellness Benefits as part of the Plan for two main purposes – (1) to assist eligible Participants and Dependents with medical conditions and treatment that are the subject of the Wellness Benefits, and (2) to determine, underwrite, classify and administer financial risks of the Plan.

(i) Summary of Benefits and Coverage (SBCs). Each HIPAA Separate Program has one or more SBCs that describe the benefits and coverage provided under the HIPAA Separate Program. The SBCs do not amend, replace or supplement the applicable SPDs for the HIPAA Separate Programs or this Plan document. Nothing in an SBC makes an Employee, Dependent or any other individual eligible for a HIPAA Separate Program, this Plan or any benefits thereunder, unless and until the applicable SPD and this Plan document provide for such eligibility or benefits. Eligibility and benefits will only be determined in accordance with and subject to the applicable SPD and this Plan document.

(j) Prohibited Services and Items. Certain state or local laws may restrict (1) the scope of health care services that a provider may render and/or (2) the scope of health care items that a provider may prescribe or furnish. In such case, the applicable Separate Programs will not cover such health care services or health care items. The Plan (and each applicable Separate Program) does not cover, pay for or reimburse health care services or health care items that are prohibited by state or local law and which are illegally performed, prescribed or furnished in such state or locality.

4.2 Coverage Period and Forfeitures.

(a) Coverage Period Limitation. Except as otherwise expressly provided in the applicable SPD, for any Coverage Period, benefits are provided only if the eligible claim is incurred

during the Coverage Period and while the individual is properly enrolled in the Plan as a Participant or Dependent.

(b) Forfeiture of Unfiled Claims. All claims must be filed with the applicable Contract Administrator within the time period specified in the SPD, or if none is specified in the SPD, within one year of the Service Date. Except as prohibited under applicable law, any claim filed with a Contract Administrator after the date specified in the preceding sentence shall be considered to be forfeited and void and shall not be processed or paid by the Contract Administrator unless otherwise specially provided in the applicable SPD.

(c) Forfeiture of Filed and Paid Claims. Except as otherwise expressly provided in any applicable SPD, any check not presented for payment (or any other form of payment that does not result in a fully completed payment transaction or process) within twelve (12) months of the date printed on the check (or for any other form of payment the date the payment transaction or process was initiated by the Plan) or such shorter period described in the applicable SPD shall, together with the claim or claims for the Plan benefits related to such check (or other payment), become void and shall be forfeited by the person or persons who were entitled to such Plan benefits. Before the end of the period described in the preceding sentence, the Contract Administrator shall make such reasonable efforts to locate the check or payment recipient that it deems reasonable and appropriate under the circumstances.

(d) Wellness Incentives or Contributions. The payment of any wellness incentive and/or contribution to, or on behalf of, a Participant or Dependent is entirely contingent on such Participant or Dependent fully satisfying the applicable terms and conditions to receive the wellness incentive or contribution, including any deadlines to receive payment of such incentives and/or contributions and any requirement to be employed on the date that payment is made. If a Participant or Dependent does not completely satisfy the conditions for payment by the applicable deadline set forth in the applicable SPD, then such wellness incentive and/or contribution shall be forfeited by the Participant and Dependent.

(e) Waiver: The Plan Administrator may waive any filing deadline under this Section if it determines that waiver is appropriate given exceptional and compelling facts and circumstances.

(f) Scope: Sections 4.2(a) through (c) shall not apply to any Separate Program that is an Insured Plan; the terms of the applicable insurance policy or contract shall control.

4.3 Coverage Levels.

For each Coverage Period and each Separate Program, the Plan Administrator will designate the dollar level(s) or coverage level(s) available (*e.g.*, employee-only, employee plus one, etc.) for health benefits as set forth in the SPD and the applicable enrollment materials. The Plan Administrator may designate the dollar level or coverage level, if any, assigned to a Participant if the Participant fails to properly and timely complete an election. The Company may impose a surcharge for coverage of a spouse or other individual eligible for coverage, for tobacco users or for other groups or individuals in accordance with applicable law.

4.4 Benefits and Participation Conditioned on Cooperation.

Each Participant and Dependent must cooperate fully with the Plan Administrator, the Insurer and the Contract Administrator, and must respond promptly to inquiries from the Plan Administrator, Insurer and Contract Administrator. In addition, with respect to the Insured Plans, each Participant and

Dependent must satisfy the requirements of the applicable policy and with respect to a Self-Insured Health Plan, each Participant and Dependent must satisfy the requirements of the following paragraphs.

(a) The Participant or Dependent for whom treatment is intended must timely undergo (and fully cooperate with) any part of a medical examination required by the Contract Administrator at a location designated by the Contract Administrator.

(b) The Participant or Dependent must timely provide all information and documents requested by the Contract Administrator or Plan Administrator, including information and documents relating to an individual's status and eligibility as a Dependent under the Plan, and must timely complete any form required by the Contract Administrator or Plan Administrator.

(c) The Participant or Dependent must:

(1) Provide information on a Third Party who may be responsible for any injury to the Participant or Dependent,

(2) Enter into any subrogation or reimbursement agreement requested by the Contract Administrator or Plan Administrator,

(3) Reimburse the Plan in accordance with a reimbursement agreement (or for any benefits that would have been subject to reimbursement, if a reimbursement agreement had been entered into),

(4) Reimburse the Plan in accordance with the subrogation and reimbursement provisions, and

(5) Cooperate fully with the Contract Administrator or Plan Administrator in protecting the Plan's subrogation and reimbursement rights with respect to any benefits covered by the Plan.

(d) The Participant and/or Dependent must provide a Contract Administrator with a consent to release to the Contract Administrator medical or other information determined by the Contract Administrator to be relevant to a claim under this Plan. Each consent will be all-encompassing but, to the extent required under Federal or state law, will be limited and will specify the types of information requested.

(e) The Participant and/or Dependent must comply with a request by the Contract Administrator to obtain medical or other information, including information in accordance with a consent under subsection (d) above, which the Contract Administrator determines to be necessary to process a claim, directly from the medical record holder or other person having custody of this information, and then to turn this information over to the Contract Administrator for the purpose of evaluating the claim.

(f) The Participant and each Dependent must keep the Contact Administrator and the Plan Administrator currently informed as to:

(1) The Participant's and Dependent's current address and contact information, and

(2) The Participant's and Dependent's full legal name, married status, social security number and any other information needed to administer the Plan.

(g) If a Participant or Dependent fails to cooperate with the Plan Administrator or a Contract Administrator as provided above, the Plan Administrator shall have the authority to terminate the Participant's or Dependent's participation in the Plan. Prior to termination of Plan participation under this Section or in lieu of terminating Plan participation, the Plan Administrator may suspend payment of Plan benefits until such time as the Participant or Dependent complies with the terms of the applicable provision, at which time Plan benefits shall commence or recommence, either retroactively or prospectively as determined by the Plan Administrator. Any such termination or suspension is subject to review under the claims procedures set forth in Sections 6.3 and 6.4 and the rescission rules of Section 3.5. If a Participant or Dependent fails to reimburse the Plan pursuant to subsection (c), the Plan is authorized to reduce the Participant's or Dependent's current and future Plan benefits up to the amount that the Participant or Dependent was required to reimburse the Plan. Such reduction shall be spread over and reduce the Participant's or Dependent's current and future Plan benefits in accordance with the rules of the Plan Administrator as in effect at the applicable time.

4.5 Insured Plans.

Sections 4.6 through 4.10 shall not apply to Insured Plans; the provisions of the applicable contract or policy shall control.

4.6 Right of Reimbursement and Recovery.

(a) General. The Plan shall have the right to recover from any Third Party or any Participant or Dependent (by judgment, compromise, settlement or any other method) any amounts received or to be received by or on behalf of a Participant or Dependent in connection with an injury, illness or condition that is a covered expense of the Plan or for which the Plan paid or will pay benefits. Neither the "make whole doctrine" nor the "common fund doctrine" apply to the Plan.

(1) Whenever a Third Party is legally responsible or agrees to compensate (or has compensated) the Participant or Dependent, by settlement, verdict or otherwise, for an illness, injury or other condition of the Participant or Dependent, the Plan will be entitled to reimbursement for any payments it has made (and will make in the future) hereunder to compensate the Participant or Dependent for the illness, injury or other condition. The Participant or Dependent must promptly reimburse the Plan for any benefits it has paid (and will pay in the future) relating to that illness, injury or condition, up to the full amount of the compensation received from the Third Party, regardless of how that compensation may be characterized (e.g., the Plan is entitled to recover from the Third Party even if the amount is designated as for pain and suffering, for non-economic damages or for wage replacement or lost earnings) and regardless of whether the Participant or Dependent has been made whole.

(2) The reimbursement required under this Section will not be reduced to reflect any costs or attorneys' fees incurred in obtaining the payment from the Third Party, unless separately agreed to (and only to the extent agreed to), in writing, by the Contract Administrator or Plan Administrator, in the exercise of its sole discretion. The Plan's right to reimbursement applies regardless of whether the Participant or Dependent recovers less than initially claimed (or less than his or her full loss), and even if the recovery is designated as not for the related expenses. In addition, the right of full and unreduced reimbursement shall also apply even if the rights of the Plan are separated and treated as not resolved in the judgment, settlement, verdict or insurance proceeds (but in this case the Plan's rights shall be assigned to the Participant or Dependent to the extent reimbursement is actually received out of the recovery). The Plan's right to receive any payment, reimbursement or recovery discussed in this Section – (i) supersedes and has priority over a Participant's or Dependent's right to

receive any payment, reimbursement or recovery, and (ii) supersedes any applicable state laws that otherwise may directly or indirectly conflict with the provisions of this Section.

(3) If a similar right to reimbursement applies to the same recovery with respect to one or more other benefit plans, the amount recovered under another benefit plan shall not reduce the amount reimbursable hereunder. If the total amount recovered from the Third Party is less than the benefits paid (and related expenses) under all such plans (and this Plan), the recovery shall be allocated between this Plan and such other plans as determined by the Contract Administrator or Plan Administrator, as applicable, in the exercise of its sole discretion.

(4) The amount of any recovery from a Third Party (or Participant or Dependent) shall be applied first to reimburse the Plan for (i) any Plan benefits previously paid to or on behalf of the Participant or Dependent, and (ii) any legal or collection expenses the Plan incurs in enforcing the Plan's right of reimbursement. Thereafter, any excess portion shall be applied to reduce the liability of the Plan for future Plan benefit payments with respect to the Participant's or Dependent's illness, injury or other condition. Any remaining amount shall then be paid to the Participant or Dependent.

(5) Third Party Proceeds which are held directly or indirectly by a Participant or Dependent are intangible assets of the Plan, subject to the protections of ERISA, and thus under ERISA are held by the Participant or Dependent in a constructive trust for the benefit of the Plan. Accordingly, any Participant or Dependent who directly or indirectly holds or exercises any control over Third Party Proceeds is an ERISA fiduciary with respect to such Third Party Proceeds and must hold such Third Party Proceeds for the exclusive benefit of the Plan in accordance with the requirements of ERISA. For the avoidance of doubt, a legal representative is an ERISA fiduciary solely with respect to his or her direct or indirect control of Third Party Proceeds and not with respect to his or her legal representation of the Participant or Dependent.

(b) Duty of Cooperation. Participants and Dependents must cooperate with the Plan and its agents and must sign and deliver such documents that are relevant to the protection of the Plan's right of reimbursement, including an individual reimbursement agreement. Participants and Dependents must also provide any relevant information and take such actions to assist the Plan in making a full recovery of the reasonable value of the Plan benefits provided. Participants and Dependents must not take any action that prejudices the Plan's right of reimbursement.

(c) Duty of Notification. Participants and Dependents must notify the Plan if they think a Third Party is responsible for or will compensate them for an illness, injury or condition that is covered or could be potentially covered by the Plan. Participants and Dependents must also notify the Plan of any lawsuit filed against any Third Party and notify the Plan of any settlement, verdict, insurance proceeds or other amount received or to be received by or on behalf of the Participant or Dependent.

(d) Enforcement and Recovery. In order to enforce its rights of reimbursement as provided in this Section and to ensure proper payment of expenses, the Plan may take any one or more of the following actions:

(1) The Plan is not required to enter into a repayment or reimbursement agreement. Entering into such an agreement and the terms and conditions thereof are within the sole discretion of the Plan Administrator or Contract Administrator. Notwithstanding the foregoing, the Participant and/or Dependent may be asked to sign a repayment or

reimbursement agreement as a condition of receiving Plan benefits and must cooperate with the Plan in obtaining reimbursement of Third Party Proceeds.

(2) Current and/or future Plan benefits may be reduced and/or offset (in whole or in part) in the sole discretion of the Contract Administrator (or Plan Administrator) at any time to recover any Third Party Proceeds. The reduction and/or offset of current and future Plan benefits (in whole or in part) shall be accomplished by the Contract Administrator or Plan Administrator (in its sole discretion) as a right of administrative setoff without the need to initiate any legal action. The Plan Administrator or Contract Administrator may reduce and/or offset Plan benefits from and after a designated date, even if Plan benefits were not reduced and/or offset prior to a designated date.

(3) The Plan may initiate legal action against the Participant or any Dependent (or anyone else holding the proceeds, such as a legal representative or trust) to collect the Third Party Proceeds. The Plan may also initiate legal action against the Participant or any Dependent to collect the amount of Plan benefits paid to or on behalf of the Participant or any Dependent with respect to the illness, injury or condition for which the Participant or any Dependent received, directly or indirectly, compensation from or on behalf of the Third Party.

(4) The Plan may take any other actions allowed by applicable law.

(e) Grant of Plan Rights. In order to recover any amount to which the Plan has a right of reimbursement or recovery under this Section, each Participant and Dependent, as a condition of receiving benefits under the Plan, grants to the Plan the following rights:

(1) A first priority equitable lien against the Third Party Proceeds or other amounts received by or on behalf of the Participant or Dependent from or on behalf of any Third Party that may be responsible for an illness, injury or condition of the Participant or Dependent (or responsible for a payment relating thereto) for which the Plan paid benefits. Such lien shall be equal to the amount of benefits paid and to be paid in the future by the Plan for the illness, injury or condition for which the Third Party is responsible (or responsible for a payment relating thereto). In addition, the Participant or Dependent shall take all actions to assign to the Plan any benefits the Participant or Dependent may have under any automobile policy or other applicable insurance policy or coverage, to the extent of the Plan's claim for reimbursement, as determined by the Plan Administrator.

(2) The right to impose a constructive trust on the Third Party Proceeds or other amounts awarded, transferred or paid by or on behalf of a Third Party to or on behalf of the Participant or Dependent and any other person or entity holding or that will hold such proceeds, including a legal representative or trust fund.

(3) The right of administrative setoff against current and/or future Plan benefits without the need to bring any legal action or proceeding

(4) The right to bring any legal action or proceeding with respect to the enforcement of any rights in this Section in any court of competent jurisdiction as the Plan may elect, and upon receiving benefits under the Plan, the Participant or Dependent hereby submits to each such jurisdiction, waiving any and all rights that may correspond to him or her by reason of his or her present or future residence.

(f) Special Definitions. Solely for purposes of this Section, the term "Participant" includes the legal representative, estate and heirs of the Participant, and the term "Dependent" includes the Participant's spouse or domestic partner, the Participant's children, any other person that the Participant has enrolled for Plan coverage and the legal representatives, estates and heirs of the foregoing.

(g) Coordination of Benefits: For purposes of any coordination of benefits provisions, requirements or rules, a Third Party shall pay primary, and the Plan shall pay secondary.

(h) No Equitable Defenses for Reimbursement. The Plan's right of reimbursement shall apply without regard to any equitable defenses that a Participant or Dependent asserts or may be entitled to assert, including without limitation any defense of unjust enrichment. ERISA shall preempt any state or local law, or any regulation issued thereunder, which prohibits or attempts to limit the Plan's right of reimbursement.

4.7 Right of Subrogation.

(a) Subrogation Rights of the Plan. Whenever a Third Party is legally responsible or agrees to compensate a Participant or Dependent for an illness, injury or other condition that is a covered expense of the Plan or for which the Plan paid or will pay benefits, the Plan may assume any rights the Participant or Dependent may have against the Third Party. Therefore, the Plan is subrogated to all of the rights of the Participant or Dependent against any party liable for the illness, injury or condition that caused, directly or indirectly, the Participant's illness, injury or condition to the extent of the reasonable value of the benefits provided or to be provided under the Plan. The Plan may assert this right independently of the Participant or Dependent. The Plan expressly rejects and overrides any default rule that the Plan does not have a right of subrogation until the Participant or Dependent has been fully compensated. The Plan's rights provided by this Section shall supersede any applicable state laws that otherwise may directly or indirectly conflict with the provisions of this Section.

(b) Duty of Cooperation. The Participant or Dependent is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information, assistance and documents that help the Plan obtain its subrogation rights, signing and delivering such documents to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of related expenses. If the Participant or Dependent enters into litigation or settlement negotiations regarding the obligations of other parties, they must not prejudice, in any way, the subrogation rights of the Plan. If a Participant or Dependent refuses or fails to cooperate with the Contract Administrator under this Section, the Contract Administrator may deny the payment of Plan benefits and may initiate actions to collect prior Plan benefits that were paid. The Contract Administrator may deny Plan benefits from and after a designated date, even if Plan benefits were approved prior to the designated date.

(c) Costs of Legal Representation. The costs of legal representation of the Plan in matters related to subrogation will be paid for solely by the Plan. The costs of legal representation of the Participant or Dependent must be paid for solely by the Participant or Dependent.

(d) Meaning of Participant and Dependent. Solely for purposes of this Section, the term "Participant" includes the legal representative, estate and heirs of the Participant, and the term "Dependent" includes the Participant, the Participant's spouse or domestic partner, the Participant's children, any other person that the Participant has enrolled for Plan coverage and the legal representatives, estates and heirs of the foregoing.

(e) No Equitable Defenses for Subrogation. The Plan's right of subrogation shall apply without regard to any equitable defenses that a Participant or Dependent asserts or may be entitled to assert, including without limitation any defense of unjust enrichment. ERISA shall preempt any state or local law, or any regulation issued thereunder, which prohibits or attempts to limit the Plan's right of subrogation.

4.8 Recovery of Improper Payments.

(a) Recovery. If any Participant, Dependent, individual, person, entity or party (the "Recipient") receives, directly or indirectly, an Improper Payment (as defined below) from the Plan, the Recipient must pay back to the Plan the full amount of the Improper Payment pursuant to the applicable rules and procedures of the Plan Administrator. In addition, any Participant and Dependent to whom the Improper Payment relates and any other individual, person, entity or party that the Plan Administrator determines to be involved with or related to the Improper Payment (a "Related Party") must assist the Plan Administrator and the Contract Administrators in recovering the Improper Payment from the Recipient.

(b) Penalties. If a Participant, Dependent, Recipient or Related Party that is required to repay an Improper Payment or assist in recovering an Improper Payment under subsection (a) fails to repay or assist in a recovery of an Improper Payment, the Plan Administrator shall have the right, in its sole discretion:

(1) To suspend the payment of all Plan benefits to or on behalf of the Participant, Dependent, Recipient or Related Party for any period of time that the Plan Administrator deems appropriate; and

(2) To terminate the participation in the Plan of the Participant, Dependent, Recipient or Related Party for any period of time that the Plan Administrator deems appropriate.

(c) Other Remedies. Nothing in this Section shall restrict, limit or otherwise hinder the Plan from pursuing any of its rights or remedies to recover Improper Payments under any applicable law.

(d) Improper Payment Defined. Any payment of Plan benefits that the Plan Administrator determines, in its discretion, to be improper under the terms of the Plan, Separate Program or applicable SPD, including:

(1) Payments of Plan benefits that have been directed to or received by the wrong Recipient;

(2) Payments of Plan benefits that have not been properly authorized by the Contract Administrator or Plan Administrator; or

(3) Payments of Plan benefits subject to Section 3.2(h).

4.9 Overpayments.

(a) General: The Contract Administrator and/or Plan Administrator shall take such steps as it deems necessary to obtain prompt repayment of any Overpayments (as defined below) made under or relating to the Plan, including requiring immediate repayment where it deems appropriate. Toward this end, the Contract Administrator and/or the Plan Administrator may require that an agreement

by the Participant or Dependent to repay Overpayments shall be included as part of an application for benefits whenever, in its discretion, this might contribute to safeguarding the Plan. Such agreement may provide for direct repayment by the Participant or Dependent, withholding the Overpayment from any future benefit from the Plan, withholding the Overpayment from any source of funds to be paid by the Company, assignment of rights to receive income or payments, and transfers of liquid assets. The failure of the Contract Administrator and/or Plan Administrator to obtain an agreement, however, shall not limit the Contract Administrator's and/or the Plan Administrator's right to recover an Overpayment.

(b) Reduction of Benefits. Current or future Plan benefits may be reduced and/or offset (in whole or in part) in the sole discretion of the Plan Administrator and/or Contract Administrator at any time to recover any Overpayment, to recover any debt owed by the Participant and/or Dependent to any member of the Smiths Group Organization, and to recover any reimbursement or payment owed by the Participant and/or Dependent to any member of the Smiths Group Organization. The reduction and/or offset in current and/or future Plan benefits (in whole or in part) shall be accomplished by the Plan Administrator (in its sole discretion) as a right of administrative set off without the need to initiate any legal action. The Plan Administrator may reduce and/or offset Plan benefits from and after a designated date, even if Plan benefits were not reduced and/or offset prior to a designated date.

(c) Other Remedies. Nothing in this Section shall restrict, limit or otherwise hinder the Plan, the Plan Administrator, a Contract Administrator or the Company from pursuing any of its rights or remedies to recover Overpayments under any applicable law.

(d) Overpayments. For purposes of this Section, the term, "Overpayment," shall include (1) any payment of Plan benefits received by or on behalf of the Participant or Dependent, which the Participant or Dependent is not entitled to under the terms of the Plan, (2) any payment of Plan benefits received by or on behalf of the Participant or Dependent, which are in excess of the amount necessary to satisfy the requirements of this Plan, and (3) any additional payment of Plan benefits to or on behalf of a provider where the Plan has previously paid Plan benefits to or on behalf of a Participant or Dependent and such individual has failed to remit all or a portion of the previous payment(s) to the provider. The term "Overpayment" shall also include any legal costs, attorneys' fees and court costs incurred as a result of or relating to the Overpayment.

4.10 Coordination of Benefit Rules.

This Plan will coordinate benefits payable with any other benefit plan or program that covers the Participant and/or Dependent, including each of the following benefit plans or programs listed as follows (collectively, "Benefit Plans"):

(a) Any group or individual health insurance plan, program, policy or contract, including an ERISA group health plan. These Benefit Plans shall pay primary or secondary pursuant to the rules listed in the applicable SPD.

(b) The medical care component of any group or individual long-term care plan, policy or contract. These Benefit Plans shall pay primary to this Plan, and this Plan shall pay secondary.

(c) To the extent permitted by law, Medicare, Medicaid and any other government sponsored health care plan, program or policy. These Benefit Plans shall pay primary or secondary to this Plan based on applicable law.

(d) Any group or individual automobile insurance policy or contract, including uninsured motorist coverage, underinsured motorist coverage, no-fault automobile insurance coverage

and traditional fault-based automobile insurance coverage. These Benefit Plans shall pay primary to this Plan, and this Plan shall pay secondary.

(e) The medical care or other compensation component of a personal umbrella insurance policy or contract. These Benefit Plans shall pay primary to this Plan, and this Plan shall pay secondary.

(f) The medical care or other compensation component of a homeowner's or renter's insurance policy or contract. These Benefit Plans shall pay primary to this Plan, and this Plan shall pay secondary.

(g) Workers' compensation or similar insurance or coverage. These Benefit Plans shall pay primary to this Plan, and this Plan shall pay secondary.

(h) The medical care or other compensation component of any first-party insurance policy, contract or coverage. These Benefit Plans shall pay primary to this Plan, and this Plan shall pay secondary.

Notwithstanding the above, the Plan shall not coordinate benefits with any policy or coverage classified as an individual cancer, individual specific disease or individual hospital indemnity policy (e.g., individual policies sold by AFLAC).

4.11 Mental Health Parity Requirements.

(a) General. Each HIPAA Separate Program providing both medical and surgical benefits and mental health benefits shall comply with Code Section 9812, as provided in the applicable SPD for the HIPAA Separate Program. However, for purposes of any Insured Plan or HMO that is a HIPAA Separate Program, the Insurer shall be responsible for compliance with Code Section 9812 in accordance with its rules and without other application of this Plan, and the Company shall not be responsible therefor.

(b) EAP. The EAP, as a Separate Program hereunder, shall be treated as a separate arrangement the benefits of which are being provided under a separate plan or separate program of benefits for purposes of Prop. Treas. Reg. Section 54.9831-1(a)(2) and Code Section 9812. Accordingly, because the EAP only covers mental health benefit and substance use disorder benefits (and not medical and surgical benefits), the requirements of Code Section 9812 shall not apply to the EAP.

4.12 Benefits Required by the Affordable Care Act.

(a) Benefits. Each HIPAA Separate Program shall provide benefits in compliance with the requirements of the ACA including, but not limited to, its provisions relating to preexisting condition prohibitions, patient protections, preventive care and cost-sharing. Benefits shall be provided as set forth in the applicable SPD. However, for purposes of any Insured Plan that is a HIPAA Separate Program, the Insurer shall be responsible for compliance with the foregoing requirements in accordance with its rules and without other application of this Plan, and the Company shall not be responsible therefor.

(b) Annual and Lifetime Maximums. Each HIPAA Separate Program shall not impose an individual annual or lifetime dollar maximum on Essential Health Benefits provided by the HIPAA Separate Program unless it satisfies guidance issued by the Department of Labor or Department of Treasury providing that such requirements do not apply to the HIPAA Separate Program. As provided by an applicable SPD, a separate individual annual or lifetime dollar maximum may apply to one or more

separate benefits within a HIPAA Separate Program to the extent that such benefit is not an Essential Health Benefit.

(c) Essential Health Benefits. HIPAA Separate Programs that are self-insured are not required to cover Essential Health Benefits, as defined under ACA. However, for purposes of determining compliance with PHSA section 2711, the Plan Administrator shall use any benchmark plan as determined in its sole discretion pursuant to applicable guidance. The Plan Administrator may choose a different benchmark plan for any future Plan Year.

4.13 State Plans.

Group health benefits under the Plan will be paid in accordance with any assignment of rights made by the Participant or on the Participant's behalf as required by a State Plan, to the extent required by ERISA. If payment has been made under a State Plan, and the Plan has the legal liability to make all or a portion of such payment, benefits under the Plan will be paid in accordance with any State law that provides that the State Plan has acquired the right to such benefits with respect to a Participant. The Plan will be discharged of its obligation to pay benefits to the Participant to the extent of its payment to the State Plan.

4.14 Benefit Administration.

(a) Plan Benefit Administration. As determined by the Plan Administrator in its sole discretion, any Plan Benefit of a Separate Program may be Administered by a Contract Administrator and/or the Plan Administrator in any United States location regardless of –

(1) The location or residence of the applicable Contract Administrator, Provider, Participant and/or Dependent;

(2) The location in which the service was performed, the supply was provided, the item was procured or the expense was incurred;

(3) The location or residence of the Company, Employer and/or Plan Administrator; and

(4) The location in which other Plan Benefits are Administered by the Plan Administrator and/or the same or different Contract Administrators (even if such other Plan Benefits are substantially similar to or even the same as the Plan Benefit in question).

(b) Determination. The determination made by the Plan Administrator in subsection (a) above may be made at any time including after the Plan Benefit was rendered, provided, procured or incurred. The Plan Administrator may determine that portions of the Administration of a Plan Benefit are Administered in different locations. Any ambiguity or conflict in the Plan records that relate to a determination by the Plan Administrator of the location in which a Plan Benefit is Administered shall be resolved by the Plan Administrator making a new determination which may be retroactive and/or prospective in the sole discretion of the Plan Administrator.

(c) Definitions. Solely for purposes of this Section, the following definitions apply –

(1) The term "Administered" or "Administration," shall mean the claim filing process, claim adjudication process, claim procedures process and/or the claim payment process as determined by the Plan Administrator in its sole discretion.

(2) The term, “Plan Benefit,” shall mean any separate service, supply, item or expense (or portions thereof) that are paid for or reimbursed by a Separate Program as determined by the Plan Administrator in its sole discretion.

ARTICLE V CONTRIBUTIONS

5.1 Contributions to the Plan.

To provide the benefits under the Plan, contributions are made by Participants (including Dependents where applicable) through voluntary salary reductions, by the Employer, or a combination of both. These contributions shall be used, among other things, to pay all premiums for an Insured Plan and to pay expenses for benefits and for reasonable expenses for the administration of the Plan. Participant and Dependent contributions shall be expended before Employer contributions.

5.2 Determination of Participant and Dependent Contributions.

The amount and timing of Participant and Dependent contributions are determined by the Employer in accordance with this Section.

(a) For each Plan Year or other Coverage Period, the Employer shall establish the applicable level of Participant and Dependent contribution, if any, for each type of benefit, level of coverage, eligibility group or status under each Separate Program. Contribution rates may be different based upon a Participant's or Dependent's eligible group or status under a Separate Program, and one group of Participants or Dependents may have a different contribution rate than another group of Participants or Dependents for the same level of coverage or benefits under the same Separate Program. Contribution rates will be updated by the Employer from time to time as specified in writing by the Employer and, for purposes of Article VII, incorporated herein by reference without further amendment of the Plan.

(b) For each Plan Year or other Coverage Period, the Company shall establish the applicable level of Participant and Dependent contributions for each type and level of coverage provided as COBRA coverage under a Separate Program.

(c) The Plan Administrator shall set deadlines and other procedures to provide for timely payment of contributions by Participants and Dependents and to provide for the termination of coverage for failure to make timely payment of contributions. Failure to comply with such deadlines and procedures shall result in termination of participation in the Separate Program to which such failure relates, unless waived by the Plan Administrator in its discretion.

(d) Except as otherwise expressly provided in accordance with the terms of the Cafeteria Plan, Participant and Dependent contributions shall be made on an after-tax basis.

(e) The Plan Administrator reserves the right to increase, decrease or otherwise change any contribution requirement during any Coverage Period or Plan Year notwithstanding any determination made in accordance with subsections (a), (b) or (c), above. However, increases, decreases or other changes in the contribution requirements during any Coverage Period under subsection (b) shall be made only as permitted under COBRA and applicable regulations.

(f) Notwithstanding the prior provisions of this Section 5.2, any HIPAA Separate Program may not adjust a premium or contribution amount (either individually or on a group basis) based on a health factor as provided by Code Section 9802(b)(1) or based on genetic information (as defined in Treas. Reg. Section 54.9802-3T(a)).

(g) The Plan shall not request, require or purchase genetic information (as defined in Treas. Reg. Section 54.9802-3T(a)) for the purpose of underwriting (as defined in Treas. Reg. Section 54.9802-3T(d)(1)(ii)).

(h) Any separate surcharge or penalty for not participating in a wellness program or for enrolling certain Dependents who have access to other coverage shall, together, with the regular contribution for coverage in the Separate Program, be considered as the entire contribution for coverage for the applicable Separate Program. Participants who agree to enroll in a specific Separate Program for a Plan Year, automatically agree to pay any applicable surcharge or penalty related to the Separate Program, by virtue of their agreement to enroll in such Separate Program.

5.3 Determination of Employer Contributions and Rebates.

To provide the benefits under the Plan, the Company, or the Company on behalf of the Employers, will pay all expenses for benefits and for administration of the Plan after application of Participant and Dependent contributions for the same Plan Year or Coverage Period. If a Separate Program is funded by any Employer contributions, any dividends, rebates, demutualization awards or other refunds or credits which may become payable under any insurance or service contract with respect to such benefit program shall be the property of and retained by the Company, provided such amount is not in excess of the amount of the benefit that is funded by Employer contributions and except as otherwise may be prohibited by applicable law. Any Plan expenses incurred by the Employers, Plan Administrator, committee, or delegate (other than an insurance company or Contract Administrator) will be paid by the Plan unless it is both paid by the Company and the Company does not seek reimbursement from the Plan. Any administrative expense submitted to the Plan for reimbursement will be reimbursed out of the contributions being made to the Plan by Participants or from any plan assets.

ARTICLE VI ADMINISTRATION

6.1 Allocation of Responsibility Among Fiduciaries for Plan Administration.

The Fiduciaries have only those specific powers, duties, responsibilities, and obligations as are specifically given or delegated to them under the Plan (or delegated to them by a named Fiduciary).

(a) The Plan Administrator has the responsibility for the administration of the Plan, except with respect to those areas of responsibility that are allocated to a Contract Administrator or Insurer herein. In addition, all decisions regarding a Participant's or Dependent's eligibility, participation and contributions are made by the Plan Administrator.

(b) The Contract Administrator or Insurer shall make all other decisions under the Plan relating to the amount and payment of benefits and shall administer the Plan with respect to this area of responsibility, except as otherwise provided in Section 4.1.

Each Fiduciary warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan, which authorize or provide for such direction, information or action. Furthermore, each Fiduciary may rely upon any direction, information or action of another Fiduciary as being proper under the Plan and is not required under the Plan to inquire into the propriety of any direction, information or action. It is intended under the Plan that each Fiduciary shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under the Plan and shall not be responsible for any act or failure to act of another Fiduciary, except to the extent required otherwise by ERISA.

6.2 Administration.

The Plan will be administered by the Plan Administrator or its delegate, except with respect to those areas of responsibility which are allocated to a Contract Administrator herein. The Plan Administrator may appoint or employ persons to assist in the administration of the Plan and may appoint or employ any other agents it deems advisable, including legal counsel, actuaries, auditors, bookkeepers and recordkeepers to serve at the Plan Administrator's direction. The Company agrees to indemnify and to defend to the fullest extent permitted by law any employee of an Employer serving as (or at the direction of) the Plan Administrator or as a member of a committee designated as the Plan Administrator, including any employee or former employee who served as the Plan Administrator or as a member of such committee against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Company) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

6.3 Claims Procedure Applicable to Separate Programs Providing Health Benefits.

This Section 6.3 shall apply to the Separate Programs providing health benefits. Claims for benefits and eligibility (and any other claims to the extent provided by Section 6.5) under this Plan shall be received and processed by the Plan Administrator and the applicable Contract Administrators (for purposes of this Section 6.3, each is referred to as an "Administrator") pursuant to the forms, instructions, directions and rules that have been established by the Administrator from time to time for this purpose. However, at all times, the claims process shall comply with the requirements of Department of Labor Regulation Section 2560.503-1 and shall include the provisions set forth below:

(a) Definitions. For purposes of this Section, the following terms shall have the meanings ascribed to them below:

(1) Concurrent Care Claim: A claim for benefits under the Plan concerning an ongoing course of treatment to be provided over a period of time or number of treatments.

(2) Post-Service Claim: A claim for benefits under the Plan that is not a Pre-Service Claim, including a claim that is filed after medical care has been received.

(3) Pre-Service Claim: A claim for benefits (that is not an Urgent Care Claim) with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining the benefit.

(4) Urgent Care Claim: A claim for benefits with respect to which the application of the time periods (as specified in subsection (c) below) applicable to Pre-Service Claims and Post-Service Claims:

(i) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(ii) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(b) Determination Notice. If a claim for benefits (including a request for precertification) by or on behalf of a Participant or Dependent is wholly or partially denied, the Administrator will provide (within the applicable time frame specified in subsection (c) below) a notice which shall include (to the extent required by law):

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent Plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to submit to perfect the claim and an explanation of why such material or information is necessary;

(4) A description of the Plan's claims review process, including the right to bring an action under ERISA if the claim is denied on appeal;

(5) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the Claimant and without charge);

(6) If the adverse determination is based on a medical necessity requirement, an experimental treatment exclusion or a similar restriction, either an explanation of the scientific or clinical judgment applying the restriction to the Claimant's medical circumstances or a statement that an explanation will be provided upon request and without charge; and

(7) Any other information required under ERISA.

(c) Time Periods for Initial Claims. Following a receipt of a claim for benefits, the Administrator shall notify (as required in subsection (b) above) a claimant of the Administrator's determination within the time period specified below for the category of the claim:

(1) Urgent Care Claims: The claimant shall be notified of the benefit determination as soon as possible but no later than 72 hours after the Administrator receives an Urgent Care Claim. If additional information is needed to process the claim, the Administrator shall notify the claimant of the additional information that is needed as soon as possible but no later than 24 hours after receiving the claim. The claimant shall then have 48 hours to provide the additional information. After receiving the additional information, the Administrator shall notify the claimant of its determination as soon as possible but no later than 48 hours after receipt. If the requested information is not received within the above 48-hour period, the Administrator will notify the claimant of its determination at the end of the 48-hour period.

(2) Pre-Service Claim: The claimant shall be notified of the benefit determination within 15 days of the Administrator receiving a Pre-Service Claim. If additional information is needed to process the claim, the Administrator shall notify the claimant prior to the end of the 15-day period. The claimant shall then have 45 days to provide the requested information, and during the time that a request for information is outstanding, the claim and the time periods applicable thereto shall be pended. If, for reasons beyond the control of the Administrator, an extension of time is required to process the claim, the Administrator will send to the claimant a notice of the extension, an explanation of the circumstances requiring extension and the expected date of the decision prior to the end of the 15-day period. However, in no event shall the extension exceed a period of an additional 15 days from the end of the initial 15-day period.

(3) Post-Service Claim: The claimant shall be notified of the benefit determination within 30 days of the Administrator receiving a Post-Service Claim. If additional information is needed to process the claim, the Administrator shall notify the claimant prior to the end of the 30-day period. The claimant shall then have 45 days to provide the requested information, and during the time that a request for information is outstanding, the claim and the time period applicable thereto shall be pended. If, for reasons beyond the control of the Administrator, an extension of time is required to process the claim, the Administrator shall send to the claimant a notice of the extension, an explanation of the circumstances requiring extension and the expected date of the decision prior to the end of the 30-day period. However, in no event shall the extension exceed a period of an additional 15 days from the end of the initial 30-day period.

(4) Concurrent Care Claim: If an on-going course of treatment was previously approved for a specific period of time or number of treatments and the request to extend the treatment is an Urgent Care Claim, a request to extend the course of treatment shall be decided as soon as possible but no later than 24 hours after the request is received; provided that the request is received at least 24 hours prior to the end of the previously approved treatment. If the foregoing request to extend previously approved treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be processed according to the time frames applicable to an Urgent Care Claim. If the on-going course of treatment is not an Urgent Care Claim, a request to extend this course of treatment will be considered a new claim and processed according to the Pre-Service Claim or Post-Service Claim procedures, whichever is applicable. However, the claimant will be notified of any reduction or termination of the course of treatment sufficiently in advance so as to permit a full appeal before the termination or reduction takes effect.

(d) Appeal of an Adverse Benefit Determination: If the Administrator denies all or part of a claim for benefits, the claimant shall have 180 days from the date of the denial to request a review by filing a written appeal with the Administrator. During the 180-day appeal period, the

Administrator shall provide the claimant, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant (as that term is defined in Department of Labor Regulation Section 2560.503-1(m)(8)) to the claim for benefits. As part of the written appeal, the claimant shall have the opportunity to submit written comments, documents, records and other information related to the claim for benefits and the Administrator shall reconsider the claim, taking into account all of the foregoing.

(e) Time Periods for Appealed Claims: Following a receipt of a request for review of a denied claim (as provided in subsection (d) above), the Administrator shall notify the claimant of its determination upon appeal within the time period specified below for the category of the claim:

(1) Urgent Care Claims: The claimant shall be notified of the benefit determination as soon as possible but no later than 72 hours after the Administrator receives the request for review of a denied Urgent Care Claim. If a Separate Program provides for two levels of appeal, such procedures and time frames shall be described in the applicable SPD; provided that with respect to any one of such two appeal levels the claimant shall be notified of the Administrator's determination not later than 36 hours after the receipt of the request for review.

(2) Pre-Service Claims: The claimant shall be notified of the benefit determination within 30 days after the Administrator receives the request for review of a denied Pre-Service Claim. If a Separate Program provides for two levels of appeal, such procedures and time frames shall be described in the applicable SPD; provided that with respect to any one of such two appeal levels the claimant shall be notified of the Administrator's determination not later than 15 days after the receipt of the request for review.

(3) Post-Service Claims: The claimant shall be notified of the benefit determination within 60 days after the Administrator receives the request for review of a denied Post-Service Claim. If a Separate Program provides for two levels of appeal, such procedures and time frames shall be described in the applicable SPD; provided that with respect to any one of such two appeal levels the claimant shall be notified of the Administrator's determination not later than 30 days after the receipt of the request for review.

(4) Concurrent Care Claims: For appeals of Concurrent Care Claims, the Administrator will notify the claimant of its determination within the time frame for an Urgent Care Claim, Pre-Service Claim or Post-Service Claim whichever is applicable; provided that a claimant will be notified of the determination on appeal before a reduction or termination of a course of treatment takes effect.

(f) Supplements to Procedures: The SPD may supplement or modify the procedures listed in this Section; provided that such procedures as supplemented or modified must satisfy the requirements of Department of Labor Regulation Section 2560.503-1. The Plan Administrator is authorized to establish and/or apply any specific and/or additional claims procedures, including the claims procedures listed in this Section, to the submission and consideration of any issue or matter that is not directly related to a claim for benefits. Such claims procedures may be established at any time, including after the issue or matter is first submitted to the Plan Administrator.

(g) Form of Notice: Any notice required to be sent under this Section shall be sent to the claimant in writing or through electronic media as provided by Department of Labor Regulation section 2520.104b-1(c); provided that a notice relating to an Urgent Care Claim may be provided orally with a written or electronic confirmation to follow within 3 days.

(h) Court Review of Claims. If any claim referenced in this Section is reviewed by a court, arbitrator, or any other tribunal, it shall be reviewed solely on the basis of the record before the Administrator at the time the Administrator made its determination and shall be reviewed under the arbitrary and capricious standard (i.e., the abuse of discretion standard).

(i) Special Procedures Applicable to HIPAA Separate Programs. Each HIPAA Separate Program shall comply with the applicable provisions of Department of Labor section 2590.715-2719. Each HIPAA Separate Program's applicable SPD shall disclose such procedures as required by the foregoing provisions.

6.4 Claims Procedures Applicable to All other Separate Programs.

Except as provided in Section 6.3, claims for benefits and eligibility (and any other claims to the extent provided by Section 6.5) under this Plan shall be received and processed by the Plan Administrator, and the applicable Contract Administrator (for purposes of this Section 6.4, each is referred to as an "Administrator") pursuant to the forms, instructions, directions and rules that have been established by the Administrator from time to time for this purpose. However, at all times, the claims process shall comply with the requirements of Department of Labor Regulation Section 2560.503-1 and shall include the provisions set forth below:

(a) Determination Notice. If a claim for benefits by or on behalf of a Participant or Dependent is wholly or partially denied, the Administrator will provide (within the applicable time frame specified in subsection (b) below) a comprehensible notice setting forth:

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent Plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to submit to perfect the claim and an explanation of why such material or information is necessary;

(4) A description of the Plan's claims review process, including the right to bring an action under ERISA if the claim is denied on appeal; and

(5) Any other information required under ERISA.

Effective for disability claims filed after April 1, 2018, in the case of an adverse benefit determination, the notice will include all the information required under the updated ERISA regulations under Section 503, which includes a discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views presented by the claimant of health care professionals treating the claimant and vocational professionals who evaluated the claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination, and (iii) a disability determination made by the Social Security Administration.

Further, if the adverse benefit determination regarding the disability benefits is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will include either 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, either the specific internal rules, guidelines, protocols, standards or other similar criteria relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines,

protocols, standards or other similar criteria of the Plan do not exist, and 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. With respect to any notice of an adverse benefit determination on appeal, in addition to the above information, the notice will include any applicable contractual limitations imposed by the Plan that applies to the right to bring legal action following the appeal, including the calendar date on which such period expires.

(b) Time Periods for Initial Claims. Following a receipt of a claim for benefits, the Administrator shall notify (as required in subsection (a) above) a claimant of the Administrator's determination no later than 90 days (45 days for disability claims) after the administrator receives the claim. If, for reasons beyond the control of the Administrator, an extension of time is required to process the claim, the Administrator shall send to the claimant a notice of the extension, an explanation of the circumstances requiring extension and the expected date of the decision prior to the end of the initial 90-day period or 45-day period, as applicable. However, in no event shall the extension exceed a period of an additional 90 days (30 days for disability claims) from the end of the initial period.

(c) Appeal of an Adverse Benefit Determination. If the Administrator denies all or part of a claim for benefits, the claimant shall have 60 days (180 days for disability claims) after receiving the denial to request a review by filing a written appeal with the Administrator. During the appeal period, the Administrator shall provide the claimant, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant (as that term is defined in Department of Labor Regulation Section 2560.503-1(m)(8)) to the claim for benefits. As part of the written appeal, the claimant shall have the opportunity to submit written comments, documents, records and other information related to the claim and the Administrator shall reconsider the claim, taking into account all of the foregoing. Effective for claims filed after April 1, 2018, with respect to claims for disability benefits, before an adverse benefit determination on review is provided, the claimant shall be provided, free of charge, any new or additional evidence considered, relied upon, or generated in making the benefit determination in connection with the claim, as well as any new or additional rationale, as soon as possible and sufficiently in advance of the notice on review to give the claimant a reasonable opportunity to respond prior to that date.

(d) Time Periods for Appealed Claims. Following a receipt of a request for review of a denied claim (as provided in subsection (c) above), the Administrator shall notify the claimant of its determination upon appeal within 60 days (45 days for disability claims) after the Administrator receives the request for review of a denied claim. If, for reasons beyond the control of the Administrator, an extension of time is required to process the appeal, the Administrator shall send to the claimant a notice of the extension, an explanation of the circumstances requiring extension and the expected date of the decision prior to the end of the initial 60-day or 45-day period, as applicable. However, in no event shall the extension exceed a period of an additional 60 days (45 days for disability claims) from the end of the initial period.

(e) Supplements to Procedures. The SPD may supplement or modify the procedures listed in this Section, provided that such procedures as supplemented or modified must satisfy the requirements of Department of Labor Regulation section 2560.503-1. The Plan Administrator is authorized to establish and/or apply any specific and/or additional claims procedures, including the claims procedures listed in this Section, to the submission and consideration of any issue or matter that is not directly related to a claim for benefits. Such claims procedures may be established at any time, including after the issue or matter is first submitted to the Plan Administrator.

(f) Form of Notice. Any notice required to be sent under this Section shall be sent to the claimant in writing or through electronic media as provided by Department of Labor Regulation section 2520.104b-1(c).

(g) Court Review of Claims. If any claim referenced in this Section is reviewed by a court, arbitrator, or any other tribunal, it shall be reviewed solely on the basis of the record before the Administrator at the time the Administrator made its determination and shall be reviewed under the arbitrary and capricious standard (i.e., the abuse of discretion standard).

6.5 Exhaustion of Claims Procedures.

(a) Before filing any Claim (including a suit or other action) in court or in another tribunal, a Claimant must first fully exhaust all of the Claimant's actual or potential rights under the claims procedures of Sections 6.3 and 6.4.

(b) Upon review by any court or other tribunal, the exhaustion requirement of this Section 6.5 is intended to be interpreted to require exhaustion in as many circumstances as possible (and any steps necessary to clarify or effect this intent may be taken).

(c) In any action or consideration of a Claim in court or in another tribunal following exhaustion of the Plan's claims procedure as described in Sections 6.3 and 6.4, the subsequent action or consideration shall be limited, to the maximum extent permissible, to the record that was before the Plan Administrator in the claims procedure process.

(d) The exhaustion requirement of this Section 6.5 shall apply – (1) regardless of whether other Disputes that are not Claims (including those that a court might consider at the same time) are of greater significance or relevance, (2) to any rights the Plan Administrator may choose to provide in connection with novel Disputes or in particular situations, (3) regardless of whether the rights are actual or potential, and (4) even if the Plan Administrator has not previously defined or established specific claims procedures that directly apply to the submission and consideration of such Claim (in which case the Plan Administrator upon notice of the Claim shall either promptly establish such claims procedures or shall apply or act by analogy to the claims procedures of Sections 6.3 and 6.4 that apply to claims for benefits.

(e) The Plan Administrator may make special arrangements to consider a Claim on a class basis or to address unusual conflicts concerns, and such minimum arrangements in these respects shall be made as are necessary to maximize the extent to which exhaustion is required.

(f) For purposes of this Section 6.5, the following definitions apply –

(1) A "Dispute" is any claim, dispute, issue, assertion, allegation, action or other matter.

(2) A "Claim" is any Dispute that implicates in whole or in part any one or more of the following –

(i) The interpretation of the Plan or any term or condition of the Plan;

(ii) Whether the Plan or any term or condition under the Plan has been validly adopted or put into effect;

(iii) The administration of the Plan;

(iv) Whether the Plan, in whole or in part, has violated any terms, conditions or requirements of ERISA or other applicable law or regulation, regardless of

whether such terms, conditions or requirements are, in whole or in part, incorporated into the terms, conditions or requirements of the Plan;

(v) A request for Plan benefits or an attempt to recover Plan benefits;

(vi) An assertion that any entity or individual has breached any fiduciary duty; or

(vii) An assertion that any individual or entity is a Participant, former Participant, Dependent, former Dependent, Plan beneficiary, former Plan beneficiary or assignee of any of the foregoing; or

(viii) Any Dispute or Claim that: (i) is deemed similar to any of the foregoing by the Plan Administrator, or (ii) relates to the Plan in any way.

(3) A "Claimant" is any Employee, former Employee, Participant, former Participant, Dependent, former Dependent, Plan beneficiary, former Plan beneficiary or any other individual, person, entity, estate, heir, or representative with a relationship to any of the foregoing individuals or the Plan, as well as any group of one or more of the foregoing who has a Claim. A "Claimant" also includes any individual or entity who is alleging the individual or entity has the status of a Participant, former Participant, Plan beneficiary, former Plan beneficiary, Dependent, former Dependent or any other individual or entity asserting a Claim.

6.6 Limitations on Actions.

Any claim, suit or action filed in court (or any other tribunal) by or on behalf of a Claimant (as defined in Section 6.5) with respect to this Plan must be brought and filed within the applicable timeframe that relates to the claim, suit or action, listed as follows:

(a) Any claim, suit or action relating to the alleged wrongful denial of Plan benefits (in whole or in part) provided by an Insured Plan must be brought by the date established for such purpose in the contract or policy.

(b) Any claim, suit or action relating to the alleged wrongful denial of Plan benefits (in whole or in part) provided by a Separate Program that is not insured, or related to eligibility for the Plan or a Separate Program must be brought within:

(1) One year of the date of the Plan's final determination of the claim in accordance with the applicable claims procedures; or

(2) If the Claimant does not exhaust in a timely manner his or her rights with respect to the Plan's administrative remedies described in Sections 6.3 and 6.4, two years after the date the claim arose.

(c) Any other claim, suit or action, including a claim that does not relate to an alleged wrongful denial of Plan benefits, must be brought within two years of the date the Claimant has actual or constructive knowledge of the claim or action or such longer period expressly required by ERISA.

(d) Any claim, suit or action not filed or brought within the aforementioned timeframes shall be null and void. Any communications (including any communications related to the

mandatory claim and appeal procedures in Sections 6.3 and 6.4) from or by the Company or an Employer, Contract Administrator, Plan Administrator or any other person or entity related or affiliated with the Smiths Group Organization shall not toll the above timeframes and shall have no effect whatsoever on the above timeframes.

6.7 Restriction of Venue.

Except as provided otherwise in a contract or policy with respect to any Insured Plan, any claim or action filed in court or any other tribunal in connection with the Plan or the Plan Administrator by or on behalf of a Claimant (as defined in Section 6.5) shall only be brought or filed in the United States District Court for the District of Columbia.

6.8 Administrative Powers and Duties.

(a) Plan Administrator. The Plan Administrator shall have such powers and duties as may be necessary to discharge its functions hereunder, including the power and duty:

(1) To exercise its discretionary authority:

(i) to construe and interpret the Plan (except with respect to matters reserved to a Contract Administrator hereunder),

(ii) to decide all questions of enrollment and eligibility,

(iii) to otherwise exercise its discretion in the administration of the Plan,

(iv) except in the case of an Insured Plan, to determine the availability, amount, manner and time of payment of, or any fact related to, any benefits under the Plan;

(v) except in the case of an Insured Plan and to the extent not delegated to a Contract Administrator hereunder, to make all decisions and to send all notices of denied benefit claims under the provisions of Sections 6.3 and 6.4; and

(vi) to make any determination pursuant to Section 4.14.

(2) To prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, information explaining the Plan;

(3) To receive from Employees, Participants, Dependents, beneficiaries, and their agents and from Employers such information as shall be necessary for the proper administration of the Plan;

(4) To appoint or employ individuals or other parties to assist in the administration of the Plan and any other agents it deems advisable, including accountants, legal counsel, bookkeepers and recordkeepers;

(5) To delegate to other persons or entities, or to designate or employ persons to carry out any of the Plan Administrator's fiduciary duties or responsibilities or other functions under the Plan; and

(6) To prescribe procedures to be followed by Participants and Dependents to authenticate their enrollment in the Plan, to prove they are validly enrolled in the Plan and satisfy the Plan's enrollment terms and conditions and to request benefits.

(b) Contract Administrator. Any Contract Administrator or Insurer shall have such powers and duties as may be necessary to discharge its functions hereunder, with respect to the portion of the Plan for which it is the designated Contract Administrator or Insurer, including the power and duty:

(1) To exercise its discretionary authority to determine the availability, amount, manner and time of payment of any benefits hereunder and to make determinations with respect to reimbursements of the Plan and to notify claimants of such determinations in accordance with the Plan;

(2) To prescribe the procedures (supplemental to those prescribed by the Plan Administrator) to be followed by Participants and Dependents requesting benefits;

(3) To receive from Employees, Participants, Dependents, beneficiaries and their agents, and from Employers such information as shall be necessary for the proper administration of the Plan with respect to the Contract Administrator's or Insurer's areas of responsibility;

(4) To make available information explaining the Plan with respect to the Contract Administrator's or Insurer's areas of responsibility;

(5) If designated as a precertification administrator, to exercise its discretionary authority to determine the amount, manner and time of payment of any benefit for any service or treatment to be provided; and

(6) To the extent delegated to the Contract Administrator hereunder, to make all decisions and to send all notices of denied benefit claims under Sections 6.3 and 6.4; provided that if the Contract Administrator is a Fiduciary, the Contract Administrator shall make all decisions and send all notices under Sections 6.3 and 6.4 with respect to the Separate Program(s) for which it is a Fiduciary.

(c) Discretion. The Plan Administrator, Insurer and the Contract Administrator, each in its respective area of authority, have the exclusive and discretionary authority to make any decisions or determinations that are contemplated by (or permissible under) the terms of this Plan. This discretionary authority vested in the Plan Administrator, Insurer and Contract Administrator also includes the right to construe and to interpret the Plan and to determine entitlement to eligibility, coverage and benefits. As a result, benefits under this Plan will be paid only if the Plan Administrator, Insurer or Contract Administrator decides in its discretion that the Participant (or other claimant) is entitled to them. Any decisions or determinations hereunder shall be made in the absolute and unrestricted discretion of the Plan Administrator, Insurer or the Contract Administrator, whichever is appropriate, even if (1) such discretion is not expressly granted by the Plan provisions in question, or (2) a decision or determination is not expressly called for by the Plan provisions in question, and even though other Plan provisions expressly grant discretion or expressly call for a decision or determination. All decisions and determinations made by the Plan Administrator will be final, conclusive and binding on all parties. If a Contract Administrator is a Fiduciary, all decisions and determinations made in its Fiduciary capacity will be final, conclusive and binding on all parties as well. The Plan Administrator and Contract Administrator may consider the intent of the Company in making any determination, notwithstanding the provisions set forth in any document. The discretionary authority referred to above is intended to be absolute, and in any case where the extent of this discretion is in question, the Plan Administrator, Insurer

and the Contract Administrator is to be accorded the maximum discretion possible. If any exercise of this discretionary authority is reviewed by a court, arbitrator, or any other tribunal, it shall be reviewed under the arbitrary and capricious standard (i.e., the abuse of discretion standard).

(d) Audit Powers. In addition to the powers and duties set forth in subsections (a) through (c), the Plan Administrator reserves the right to audit at any time and for any Plan Year any enrollment election or other information provided in connection with a Participant's or Dependent's enrollment in the Plan. This right to audit includes auditing the status of an enrolled Dependent to determine if the Dependent satisfies the eligibility criteria. This right to audit also includes whether the correct Participant or Dependent contribution applies, including any applicable contribution surcharges. In addition to the foregoing, any audit rules set forth in an applicable SPD for the Plan shall also apply for this purpose.

6.9 Qualified Medical Child Support Orders.

The Plan Administrator will establish reasonable procedures to determine whether medical child support orders are Qualified Medical Child Support Orders and to administer benefits under such qualified orders. The Plan will provide group health benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order as required by ERISA.

6.10 Rules and Decisions.

With respect to their respective areas of responsibility under the Plan, the Plan Administrator, Insurer and the Contract Administrator each may adopt such rules and procedures as it deems necessary, desirable, or appropriate provided such rules shall be applied in a uniform manner to similarly-situated individuals. Notwithstanding any other provision of the Plan or SPD, the Plan Administrator, Insurer and Contract Administrator may prospectively revise their rules and procedures whenever they deem it appropriate, even if this causes inconsistency with prior decisions or results. When making a determination or calculation, the Plan Administrator, Insurer or Contract Administrator shall be entitled to rely upon information furnished by a Participant, a Dependent or the legal counsel of the Plan Administrator.

6.11 Procedures:

(a) The Plan Administrator shall keep all necessary records and documentation regarding the Plan. The Plan Administrator may adopt such procedures as it deems desirable for the administration of the Plan.

(b) Neither a Participant nor a Dependent may designate an authorized representative under the Plan without following the Plan's procedures or using the Plan's forms (if any) for designating an authorized representative. The procedures for designating an authorized representative shall be set forth in the applicable SPD or shall be provided upon request to the Plan Administrator. Such procedures may be different for authorizing representatives for purposes of ERISA sections 104(b)(4) and 503. Any purported designation that does not follow the Plan's procedures or does not use the Plan's form (if any) shall be null and void and shall not apply to the Plan (nor any Separate Program).

6.12 Forms and Requests for Information:

The Plan Administrator or its designee may require a Participant or Dependent to complete and file such forms as are provided for herein and all other forms approved by the Plan Administrator, and to furnish all pertinent information, facts, data and documentation requested by the Plan Administrator. The

Plan Administrator may rely upon all such information, including the Participant's or Dependent's current mailing address.

6.13 Records and Reports:

The Plan Administrator shall exercise such authority and responsibility as it deems appropriate in order to comply with ERISA and the Code relating to records of Participants' rights and benefits; notifications to Participants; reports to, or registration with, the Internal Revenue Service; reports to the Department of Labor; and such other documents and reports as may be required by the Code or ERISA.

6.14 Facility of Payment:

Whenever, in the Plan Administrator's opinion, a Participant or Dependent entitled to receive any payment of a benefit hereunder is under a legal disability or is incapacitated in any way so as to be unable to manage his financial affairs, the Plan Administrator or the Contract Administrator may direct payments to be made to such person or to the legal representative of such person for his benefit, or to apply the payment for the benefit of such person in such manner as the Plan Administrator or the Contract Administrator considers advisable. Any payment of a benefit or installment thereof in accordance with the provisions of this section shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

ARTICLE VII AMENDMENT OF THE PLAN

The Company shall have the right at any time by instrument in writing to modify, alter or amend the Plan and any Separate Program in whole or in part, provided, however, that no such amendment shall diminish or eliminate any claim for a benefit payment to which a Participant or Dependent shall have become fully entitled prior to such amendment. For purposes of the preceding sentence, a Participant or Dependent shall be deemed to be entitled to a benefit (i) in the case of a health care benefit, only to the extent of covered health care expenses which such individual has actually incurred as of such date for already provided products or services, (ii) in the case of a death benefit, only to the extent that the covered individual's death has occurred, and (iii) in the case of an accident benefit, only to the extent that a covered accident has occurred.

In addition, in the event that a specific Section or provision of this Plan document provides that the terms of an applicable SPD takes precedence over the specific terms of this Plan document or a specific Section or provision of this Plan document refers to an applicable SPD to provide the specific terms, rules, requirements, rights or benefits of this Plan document, the amendment of such SPD shall be deemed an amendment to this Plan document made in accordance with this Article without further action by the Company. Such amendment shall be effective as of the specific effective date set forth in the applicable SPD for the applicable provision, or to the extent that no specific effective date is set forth for a specific provision, then such amendment shall be effective as of the effective date that applies generally to such SPD.

While it is anticipated that the Plan will be administered based upon the assumption that certain benefits will be provided in the future, the actual benefits (if any) that the Plan will provide with respect to any Participant or Dependent remain always and completely subject to change, reduction and elimination in accordance with the terms of this Article. Similarly, although the funding of the Plan at any time may assume limited or no contributions by some or all of those covered (or a particular type of contribution), the Company and the Employers retain the unlimited right to institute contributions with respect to any individual or group, and the contributions required remain always and completely subject to increase and change.

Notwithstanding the foregoing, it is expressly permissible for the Company to reduce or eliminate benefits for one or more groups of Participants, Dependents, Employees or Separate Programs, or to make any other amendments to the Plan that affects less than all of the Participants or Dependents covered by the Plan. In addition, the Company shall have the unlimited right to amend the Plan at any time, retroactively or otherwise, in such respects and to such extent as may be necessary to fully qualify it under existing and applicable laws and regulations so as to permit the full deduction for tax purposes of the Employer contributions made hereunder, to have benefits be nontaxable to Participants under Code Sections 105 and 106, and if and to the extent necessary to accomplish such purposes, may by such amendment decrease or otherwise affect the existing entitlement of Participants or Dependents to benefits provided hereunder, notwithstanding any provision herein to the contrary.

This Plan may be amended or restated (including by ratification) by the Company, or by a committee or by any officer of the Company who has authority or who has been granted or delegated the authority to amend or restate this Plan. An amendment or restatement of this Plan shall not affect the validity or scope of any grant or delegation of such authority, which shall instead be solely determined based upon the terms of the grant or delegation (as interpreted under applicable law).

For purposes of this Article and Article VIII, a participating Employer shall not have the right to amend or terminate the Plan.

ARTICLE VIII TERMINATION OF THE PLAN

The Plan herein provided for has been established by the Company with the bona fide intention that it shall be continued in operation. However, the Company reserves the right at any time to terminate or partially terminate the Plan and/or any of the Separate Programs by written action. The Company's rights under this Article VIII shall be no less than its rights under Article VII.

Notwithstanding the above, this Plan and any Separate Program may be terminated by the Company or by a committee or by any officer of the Company who has authority or who has been granted or delegated the authority to terminate this Plan.

Upon termination of the Plan, the Plan Administrator shall make appropriate arrangements to conclude the affairs of the Plan, including providing for payment of the benefits of any Participant for whom payment has already been approved or for claims incurred before the termination is effective.

ARTICLE IX MISCELLANEOUS

9.1 Participants' Rights:

Except as required by law, neither the establishment of the Plan, nor any modification thereof, nor the creation of any fund or account, nor the payment of any benefits, shall be construed as giving to any Participant, Dependent or other person any legal or equitable right against the Company or Employer, or any officer or employee thereof, or the Plan Administrator except as herein provided. In addition, neither a Participant nor a Dependent shall have any legal right, title or interest in the assets of the Company or Employer, except in the event and to the extent that benefits may actually be payable to him hereunder. Under no circumstances shall the terms of employment of any Participant be modified or in any way affected hereby. This Plan shall not constitute a contract of employment or limit the right of the Employer to discharge any of its employees, with or without cause.

9.2 Litigation:

In any action or proceeding involving the Plan or the administration thereof, the Company and the Plan Administrator shall be the only necessary parties and no Employees, former Employees, Participants, former Participants, Dependents or former Dependents or any other person having or claiming to have an interest under the Plan shall be entitled to any notice or service of process. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive on the parties hereto, the Plan Administrator, and all persons having or claiming to have any interest under the Plan.

9.3 Successor to the Company:

In the event of the dissolution, merger, consolidation or reorganization of the Company, provision may be made by which the Plan will be continued by the successor, and, in that event, such successor shall be substituted for the Company under the Plan. The substitution of the successor shall constitute an assumption of plan liabilities by the successor and the successor shall have all the powers, duties and responsibilities of the Company under the Plan.

9.4 Application of Code Section 105(h):

Notwithstanding anything in this Plan (or the Appendix) to the contrary, for purposes of applying the nondiscrimination requirements of Code section 105(h), the Company reserves the right (a) to designate a Separate Program as constituting two or more separate plans, (b) to aggregate two or more Separate Programs into a single plan (or to aggregate this Plan with one or more other plans), and (c) to take such other action as the Company deems necessary to assure that, in the judgment of the Company, the Plan will operate in compliance with Code section 105(h). If a different waiting period or different benefits are offered to a particular group with respect to any self-insured group health plan that is a Separate Program under the Plan, such portion of the Plan shall be treated as a separate plan for purposes of applying the nondiscrimination requirements of Code § 105(h) as permitted under Treas. Reg. § 1.105-11(c)(4)(i). The Company's rights under this Section may be exercised at any time and may be applied retroactively or prospectively to the extent deemed necessary.

9.5 Participating Employers:

(a) Adoption of the Plan. This Plan may be adopted by an Employer provided that such adoption is with the approval of the Company or its designee. The coverage date for the Plan for such Employer shall be established by the Company, and from and after such effective date, such Employer shall assume all the rights, obligations, and liabilities of an individual affiliate hereunder.

(b) Administration. As a condition to adopting the Plan, and except as otherwise provided herein, each participating Employer shall be deemed to have authorized the Company or Plan Administrator, as applicable, to amend the Plan or otherwise 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.

(c) Termination of Participation. Each Employer may cease to participate in the Plan upon written notice by any authorized officer of the Employer to the Company or upon written notice by any authorized officer of the Company to the Employer.

9.6 Construction of Plan:

This Plan will be construed in accordance with this Section.

(a) Applicable Law: The provisions of the Plan will be construed and administered according to, and its validity and enforceability determined under ERISA. In the event ERISA does not preempt state law in a particular circumstance, the laws of the District of Columbia or, to the extent a determination has been made in accordance with Section 4.14, the internal laws of the location in which a Plan Benefit (as defined in Section 4.14) is administered shall govern.

(b) Order of Application: In determining and construing the provisions of the Plan applicable to any particular person or situation, the following shall be used in order of descending precedence:

(1) This Plan document;

(2) The applicable SPD;

(3) Annual enrollment materials, as recognized for this purpose by the Plan Administrator ("Recognized Enrollment Materials");

(4) The records of the Employer for factual matters;

(5) The Plan Administrator's prior decisions and interpretations; and

(6) The procedures, polices and guidelines of the applicable Contract Administrator.

Notwithstanding the foregoing, Recognized Enrollment Materials shall take precedence over the applicable SPD (but not this Plan document) when (i) the Recognized Enrollment Materials (but not the SPD) have been updated to reflect changes in benefits or procedures applicable to the Coverage Period; and (ii) the Recognized Enrollment Materials describe a clear change to the benefits or procedures described in the applicable SPD.

Notwithstanding the foregoing, (1) in the event that a specific Section or provision of this Plan document provides that the terms of an applicable SPD takes precedence over the specific terms of this Plan document, such SPD shall take such precedence over the specific terms of this Plan document solely to the extent provided in that Section or provision, and (2) in the event that a specific Section or provision of this Plan document refers to an applicable SPD to provide the specific terms of this Plan document, such SPD shall be treated as the specific terms of this Plan document solely to the extent provided in that Section or provision.

(c) Gender and Number: The masculine gender, where appearing in this Plan, shall be deemed to include the feminine gender, the singular may include the plural, and the plural may include the singular, unless the context clearly indicates to the contrary.

(d) Examples: Whenever an example is provided or the text uses the term "including" followed by a specific item or items, or there is a passage having a similar effect, such passages of the Plan shall be construed as if the phrase "without limitation" followed such example or term (or otherwise applied to such passage in a manner that avoids any limit on its breadth of application).

(e) Severability: If any provision of this Plan is, or is hereafter declared to be, void, voidable, invalid or otherwise unlawful, the remainder of the Plan will not be affected thereby.

(f) Interpreting Article VII: In all circumstances, the provisions of Article VII shall be interpreted in the manner which imposes the least limitation on the Company's claimed right of amendment. In this regard, it is specifically intended that any ambiguities in the Plan are to be resolved in the manner which minimizes the limitation on any right of amendment that is claimed directly or indirectly against one or more Employees or Participants. Notwithstanding any other provision of the Plan, it is expressly permissible for the Company to clarify the terms of this document, even retroactively, by an amendment accomplishing a good faith correction of any typographical error or inadvertent ambiguity.

(g) Effect of Specific References. Specific references in the Plan to the Plan Administrator's (or Contract Administrator's) discretion shall create no inference that the Plan Administrator's (or Contract Administrator's) discretion in any other respect, or in connection with any other provisions, is less complete or broad.

(h) Plan Rules. The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable or appropriate in order to administer the Plan. In addition, the Plan Administrator may require a Participant to file such forms and to provide such other information requested by the Plan before making the payment of benefits under the Plan. Any reference in the Plan to rules, guidelines or procedures of the Plan, Plan Administrator or Contract Administrator shall refer only to those rules, guidelines and procedures that are used by the Plan Administrator and/or Contract Administrator for the determination in question and that are effective as of the applicable time. Notwithstanding any other provision of the Plan or an SPD, the Plan Administrator and/or Contract Administrator may prospectively revise its rules, guidelines and/or procedures whenever it deems appropriate, even if this causes inconsistency with prior results.

ARTICLE X SIGNATURE

This amended and restated Plan is hereby adopted and approved, to be effective as of August 1, 2023 (unless otherwise noted herein), this _____ day of _____, 2024.

SMITHS GROUP SERVICES CORP.

By:_____

Name: _____

Title: _____

APPENDIX

The following Appendix articles modify particular terms of the Plan as it applies to certain Participant or Dependent groups and certain Separate Programs. Except as specifically modified in the Appendix, the foregoing main provisions of the Plan shall fully apply in determining the rights and benefits of Participants and Dependents. In the event of a conflict between the Appendix and the foregoing main provisions of the Plan, the Appendix shall govern.

APPENDIX - ARTICLE A SPDs INCLUDED IN THE PLAN

A.1 Scope: This Article supplements the main portion of the Plan document by identifying the SPDs incorporated in this Plan by reference thereto in accordance with Section 4.1.

A.2 SPDs: From time to time as SPDs for coverages under the Plan are distributed and/or posted, each SPD is incorporated herein, and the Plan Administrator may (but is not required to) attach a list of such SPDs to this Article A from time to time in accordance with Section 4.1 and Article VII. Any publication of SPDs on a website designated by the Company for one or more Eligible Employee groups shall be considered an automatic amendment to this Plan based on the rules set forth in Article VII.

APPENDIX SP - SEPARATE PROGRAMS

The following benefits may be offered under the Plan to all or a group of Eligible Employees and/or Retirees, and in certain cases their Dependents. Employees of different Employers or other classes of Employees may receive different packages under the various benefits.

As provided in the Plan, these benefits may be amended or terminated at any time, and changes may affect, among other things, eligibility, contribution rates, benefits coverage, etc. with respect to current or future Employees and/or Retirees, and their Dependents. These benefits do not vest, and no promise of benefits or contribution rates is intended or implied.

1. Medical Benefits (including prescription drug coverage)

2. Dental Benefits

3. Vision Benefits

4. Employee Assistance Program (EAP) Benefits

5. Flexible Spending Account Benefits (Health and Dependent Care), but these programs are described in a separate document

6. Life Insurance Benefits

7. Accidental Death & Dismemberment Insurance Benefits

8. Long-Term Disability Benefits

9. Group Voluntary Insurance Benefits (Hospital Indemnity, Accidental Injury, Cancer and Critical Illness)

APPENDIX PE (Participating Employers)

Effective as of August 1, 2023, the following divisions of Smiths Group Services Corp. are Participating Employers:

Corporate
Detection
John Crane
Interconnect
Flex-Tek – Laconia

APPENDIX - ARTICLE HIPAA – HIPAA PRIVACY AND SECURITY PROVISIONS

HIPAA.1 Scope.

This Article HIPAA supplements the main portion of the Plan document in connection with the requirements of the HIPAA Standards.

HIPAA.2 Definitions.

When used in this Article HIPAA, the following phrases shall have the meanings set forth below. Except as otherwise provided in this Article HIPAA, all terms that are defined in Article II of the main Plan document shall have the meaning assigned to them in Article II:

(a) "Breach Notification Rule" means the "Standards for Breach Notification for Unsecured Protected Health Information," 45 C.F.R. Part 164, Subpart D, as may be revised from time to time by the Secretary, including the HIPAA Omnibus Rules.

(b) "Business Associate" shall have the meaning given to it by Section 160.103 of the HIPAA Standards.

(c) "Claims Assistance" shall mean assisting Participants and Dependents with any and all issues relating to claims and/or payment of Plan benefits, including:

(1) Answering questions from Participants and Dependents concerning the status of a claim for benefits, how to process a claim for benefits and obtain proper payment, and the submission of claims for benefits;

(2) Rendering assistance to or on behalf of a Participant or Dependent in submitting a claim for benefits, and in obtaining processing and payment of a claim for benefits; and

(3) Answering questions and rendering assistance regarding all aspects of the applicable claims procedures.

(d) "Designated Record Set" or "DRS" shall have the meaning given to it by Section 164.501 the HIPAA Standards; provided, that the following information shall not be considered part of an individual's DRS:

(1) Records received by the Company or an Employer that are duplicative of the original record that is maintained by the Plan (or one or more of its Business Associates),

(2) Health information received, created and/or maintained by the Company or an Employer in its capacity as an employer (including any Employment-Related Functions) and not received from the Plan, and

(3) Records maintained by the Company or an Employer that are not part of an organized record system (*e.g.,* handwritten notes and other similar materials).

(e) "Electronic Protected Health Information" or "E-PHI" shall have the meaning given to it by Section 160.103 of the HIPAA Standards; provided however the information created, maintained, used, disclosed or transmitted pursuant to the activities of the Company or an Employer as enumerated in Section HIPAA.9 shall not be E-PHI.

(f) "Employment-Related Function" shall mean any function or activity that is not related to the Plan and that is conducted or performed by the Company or an Employer, including:

(1) Conducting employee drug testing/screening and receiving the results;

(2) Performing the Company's and Employer's obligations under the Family Medical Leave Act, the Americans with Disabilities Act and workers' compensation and other occupational injury and similar laws;

(3) Administering the Company's and/or Employer's disability benefit plans, retirement plans and sick leave programs;

(4) Conducting workplace medical surveillance of employees; and

(5) Conducting and receiving fitness-for-duty tests and examinations.

(g) "Enrollment Activities" shall mean activities performed or conducted by the Company and/or Employer relating to enrolling and disenrolling Participants and Dependents with respect to the Plan or a Separate Program, including:

(1) Determining a Participant's and Dependent's eligibility to enroll in the Plan or a Separate Program under Article III (and determining when such participation terminates);

(2) Designing and operating a system, procedures and practices to capture Enrollment Information relating to the enrollment and disenrollment of Participants and Dependents with respect to the Plan and the Separate Programs, including updating and revising their enrollment and disenrollment status with respect to the Plan and the Separate Programs during the Plan Year; and

(3) Designing and operating a system, procedures and practices for communicating, transferring, sending and receiving the Enrollment Information of Participants and Dependents with respect to the Plan and Separate Programs to and from Contract Administrators, Business Associates, Health Insurance Issuers and other designated agents.

(h) "Enrollment Information" shall mean any information or data element that may be included in the electronic transactions rule standard, ASC X12N 834, Benefit Enrollment and Maintenance, Version 4010, May 2000, as may be revised, updated and amended from time to time, including without limitation the COBRA status, elected coverage levels and options, birth date for full-time students, full-time status and social security number.

(i) "Health Insurance Issuer" shall have the meaning given to it by Section 160.103 of the HIPAA Standards and shall include an HMO, as defined by the HIPAA Standards.

(j) "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended, Public Law 104-191.

(k) "HIPAA Omnibus Rules" shall mean the rules issued by the Department of Health and Human Services at 78 Fed. Reg. 5566-5702 (January 25, 2013).

(j) "HIPAA Standards" shall mean the Privacy Rule, the Security Rule, the Breach Notification Rule, the HITECH Act and/or the HIPAA Omnibus Rules, as the context so requires.

(k) "HITECH Act" shall mean the provisions of Title XIII, Subtitle D of the American Recovery and Reinvestment Act of 2009.

(l) "Manual" shall mean the HIPAA Policies and Procedures Manual, adopted by the Plan effective as of April 14, 2003, as amended and restated effective as of April 20, 2005 (and as further amended from time to time), pursuant to the requirements of the HIPAA Standards.

(m) "Plan Administration Functions" shall mean the administration functions performed by the Company or an Employer on behalf of the Plan that meet the definition of "Payment" or "Health Care Operations" (as each term is defined in Section 164.501 of the Privacy Rule), including Claims Assistance, claims processing, auditing, fraud investigation and detection, utilization review, billing and collections, coordination of benefits, claims management, quality assurance, case management and benefit design. Notwithstanding the foregoing, the term "Plan Administration Functions" shall not include any activities relating to functions performed by the Company or an Employer in connection with (1) any other benefit or benefit plan (other than the Plan or a Separate Program) of the Company or an Employer, (2) any Employment-Related Functions, (3) any Enrollment Activities with respect to the Plan or a Separate Program and (4) any Premium Collection Activities with respect to the Plan or a Separate Program.

(n) "Premium Collection Activities" shall mean the activities conducted by the Company or Employer relating to Participant and Dependent contributions with respect to the Plan or a Separate Program.

(o) "Privacy Official" shall mean the person appointed to serve in such position, including his or her delegate or delegates.

(p) "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Part 160 and Part 164, Subparts A and E, promulgated by the Department of Health and Human Services pursuant to HIPAA, as amended from time to time.

(q) "Protected Health Information" or "PHI" shall have the meaning given to it by Section 164.501 of the HIPAA Standards; provided however, the information created, maintained, used, disclosed or transmitted pursuant to the activities of the Company or an Employer as enumerated in Section HIPAA.9 shall not be PHI; and provided further, E-PHI shall not be included as part of PHI, unless the context so requires.

(r) "Secretary" shall mean the Secretary of the Department of Health and Human Services.

(s) "Security Incident" shall have the meaning given to it by Section 164.304 of the HIPAA Standards.

(t) "Security Official" shall mean the person appointed to serve in such position, including his or her delegate or delegates.

(u) "Security Rule" shall mean the Security Standards for Protection of Electronic Protected Health Information, 45 C.F.R. Part 160, Subpart A, and Part 164, Subparts A and C, promulgated by the Department of Health and Human Services pursuant to HIPAA, as amended from time to time.

(v) "Summary Health Information" shall have the meaning given to it in Section 164.504(a) of the HIPAA Standards.

HIPAA.3 Permitted Disclosure of Enrollment Information.

The Plan (or a Health Insurance Issuer with respect to the Plan) may disclose to the Company or to an Employer any Enrollment Information regarding the Plan or Separate Program with respect to any Participant, Dependent or other individual participating (or formerly participating) in the Plan. Such disclosure is not subject to the requirements of the HIPAA Standards.

HIPAA.4 Permitted Disclosure of Summary Health Information.

Except for information that is prohibited under Section HIPAA.6(d), the Plan (or a Health Insurance Issuer with respect to the Plan) may disclose to the Company or to an Employer any Summary Health Information for the purpose of allowing the Company or an Employer to:

(a) Obtain bids from Health Insurance Issuers for providing health insurance coverage under the Plan or a Separate Program, or

(b) Modify, amend or terminate the Plan or Separate Program.

HIPAA.5 Permitted Use and Disclosure of PHI based on a Written Authorization.

The Plan (or a Health Insurance Issuer with respect to the Plan) may disclose a Participant's, Dependent's or other individual's PHI and/or E-PHI to the Company or an Employer and the Company or Employer may use such PHI and/or E-PHI, if such disclosure and/or use is authorized by the Participant, Dependent or individual pursuant to a written authorization meeting the applicable requirements of Section 164.508 of the HIPAA Standards, other than a use and/or disclosure that is prohibited by Privacy Rule Section 164.502(a)(5) or other applicable guidance.

HIPAA.6 Permitted Use and Disclosure of PHI and E-PHI for Plan Administration Functions.

(a) Permitted Use and Disclosure. Unless otherwise permitted by the Privacy Rule or other applicable law, and subject to the conditions of disclosure described in subsection (b) and the certification provisions of subsection (c), the Plan (or a Health Insurance Issuer with respect to the Plan) may disclose PHI and/or E-PHI to the Company or an Employer; provided that the Company or Employer use or further disclose such PHI and/or E-PHI only for Plan Administration Functions. Any PHI or E-PHI disclosed to the Company or an Employer by the Plan pursuant to the previous sentence shall be limited to the extent required by Section 164.502(b) of the Privacy Rule, as amended. Notwithstanding the foregoing, in no event shall the Company or an Employer be permitted to use or disclose PHI and/or E-PHI in a manner that is inconsistent with Section 164.504(f) of the Privacy Rule.

(b) Conditions of Disclosure for Plan Administration Functions. The Company and the Employers agree that with respect to any PHI and/or E-PHI disclosed to the Company and Employers by the Plan (or a Health Insurance Issuer with respect to the Plan) pursuant to subsection (a) above the Company and Employers shall:

(1) Not use or further disclose such PHI and/or E-PHI other than as permitted by the Plan or as required by law;

(2) Ensure that any agents to whom it provides such PHI agree to the same restrictions and conditions applicable to the Company and Employers with respect to the PHI, and ensure that any agents to whom it provides such E-PHI agree to implement reasonable and appropriate security measures designed to protect the E-PHI to the extent required by Section 164.314(b)(2)(iii) of the Security Rule;

(3) Not use or disclose such PHI and/or E-PHI for employment-related actions (including Employment-Related Functions) and decisions or in connection with any other benefit or employee benefit plan of the Company and Employers;

(4) Report to the Plan any use or disclosure of such PHI and/or E-PHI of which it becomes aware and which is inconsistent with the permitted uses or disclosures of the PHI and/or E-PHI;

(5) To the extent such PHI and/or E-PHI is part of a DRS, allow the individual that is the subject of the PHI and/or E-PHI to access and copy the PHI and/or E-PHI maintained in the DRS in accordance with the requirements of Section 164.524 of the HIPAA Standards;

(6) To the extent such PHI and/or E-PHI is part of a DRS, make such PHI and/or E-PHI available for amendment and incorporate any amendments to the PHI and/or E-PHI in accordance with the requirements of Section 164.526 of the HIPAA Standards;

(7) Make available such information as is required to allow the Plan to provide an accounting of disclosures of PHI and/or E-PHI to an individual in accordance with the requirements of Section 164.528 of the HIPAA Standards;

(8) To the extent applicable, honor a request submitted by an individual to the Plan in accordance with the requirements of Section 164.522(a) of the HIPAA Standards that restricts the use or disclosure (or further use or disclosure) of the individual's PHI;

(9) Make available to the Secretary its internal practices, books and records relating to the use and disclosure of PHI and/or E-PHI received from the Plan and its administrative, physical and technical safeguards that have been implemented pursuant to Section HIPAA.6(b)(12) of this Appendix as necessary for the Secretary to determine the Plan's compliance with the HIPAA Standards;

(10) If feasible, return or destroy all PHI and/or E-PHI received from the Plan once it is no longer needed for the purpose for which the disclosure was made, and if the return or destruction of the PHI and/or E-PHI is not feasible, limit the future use and disclosure of such information to those purposes which make the return or destruction of the information infeasible;

(11) Provide for adequate separation between the Plan and the Company and Employers, in the manner required by Section 164.504(f)(2)(iii) of the HIPAA Standards and Section HIPAA.7 of this Appendix, and ensure that with respect to E-PHI such separation is supported by reasonable and appropriate security measures;

(12) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of E-PHI that it creates, receives, maintains or transmits on behalf of the Plan, as those safeguards may be revised from time to time pursuant to the Security Rule; and

(13) Report to the Plan any Security Incident of which it becomes aware using protocols which are reasonable and appropriate in light of the Security Incident.

(c) Certification of Company. The Plan (or a Health Insurance Issuer with respect to the Plan) shall disclose PHI and/or E-PHI to the Company and the Employers pursuant to subsection (a) above only upon the receipt of a certification by the Company (on behalf of it and all of the Employers)

that the Plan has been amended to incorporate the provisions of Section 164.504(f)(2)(ii) and that the Company and the Employers agree to the conditions of disclosure described therein.

(d) GINA. Notwithstanding the provisions in subsections (a), (b) and (c) above, the Plan (or a Health Insurance Issuer with respect to the Plan) shall not use genetic information for underwriting purposes and shall not disclose genetic information to any person or party (including the Company or an Employer) for underwriting purposes based upon the rules set forth in Section 164.502(a)(5)(i) of the HIPAA Standards.

(e) Breach of Unsecured PHI or E-PHI. To the extent applicable and from and after the date specified in the HIPAA Omnibus Rules, if the Company and/or Employers Discover a Breach of Unsecured PHI, the Company and/or Employers shall notify the Privacy Official of such Breach as soon as practicable but in all events within sufficient time for the Plan to carry out its duties and responsibilities pursuant to the requirements of Part 164, Subpart D of the HIPAA Omnibus Rules. For purposes of this subsection (e), the terms "Breach" and "Unsecured PHI" shall have the meaning set forth in Section 164.402 of the HIPAA Standards and the term "Discover" shall have the meaning set forth in Section 164.404(a)(2) of the HIPAA Standards.

(f) Sale of PHI. From and after the date specified in the HITECH Rules, the Company and/or Employers shall not directly or indirectly receive remuneration in exchange for any PHI or E-PHI unless either (1) the Plan or the Company and/or Employers obtains a valid written authorization meeting the applicable requirements of Section 164.508 of the HIPAA Standards, or (2) one of the exceptions in Section 164.502(a)(5)(ii) of the HIPAA Standards apply.

(g) Marketing Restrictions. For purposes of a disclosure of PHI or E-PHI from the Plan to the Company and/or Employers pursuant to this Section HIPAA.6, the term "Plan Administration Function" shall not include any disclosure of PHI or E-PHI the purpose of which would violate the prohibitions on marketing as set forth in Section 164.508 of the HIPAA Standards. In addition, the Company and/or Employers shall not use or disclose any PHI or E-PHI received from the Plan pursuant to this Section HIPAA.6 that would be in violation of Section 164.508(a)(3) of the HIPAA Standards if such use or disclosure would be performed by or on behalf of the Plan.

HIPAA.7 Adequate Separation Between Plan and Company / Access to PHI.

Pursuant to Section HIPAA.6(b)(11) of this Appendix, the following individuals or groups of individuals that are under the control of the Company or the Employers are the only individuals that may access and use PHI and/or E-PHI to the extent necessary to perform Plan Administration Functions for the Plan or as required by law:

(a) Individuals who work in the Company's or an Employer's human resources departments or who are responsible for human resources functions;

(b) Individuals who work in the Company's or an Employer's benefits departments or who are responsible for benefits functions;

(c) Individuals who work in the Company's or an Employer's law or legal departments and who support human resources and/or benefits functions of the Company or an Employer;

(d) Individuals who work in the Company's or an Employer's finance or accounting departments and who support the benefits functions of the Company or an Employer;

(e) The Privacy Official, the Security Official and their delegate or delegates; and

(f) Any individual or group of individuals to the extent written permission is granted by the Privacy Official or Security Official on a case-by-case, need-to-know basis, and the designation limits the scope of authority of the individual or group of individuals to the specific function(s) that the individual or group of individuals is performing on behalf of the Plan.

If any of the individuals identified above in this Section fails to comply with the provisions of this Article HIPAA, he or she shall be subject to disciplinary action by the Company (or an Employer on behalf of the Company) pursuant to the sanctions and noncompliance policies and procedures of the Plan or the Company. In addition, any individuals identified above shall be properly trained pursuant to the requirements of the HIPAA Standards. The Privacy Official and/or the Security Official shall maintain a log of names of the individuals who from time to time have access and use PHI and/or E-PHI for Plan Administration Functions.

HIPAA.8 Claims Assistance.

Claims Assistance is a required function of the Plan, is included in Plan Administration Functions, and shall be performed and rendered by the Plan and those working on behalf of the Plan, including:

(a) The individuals authorized by the Plan in Section HIPAA.7 to perform Plan Administration Functions;

(b) The applicable Business Associates;

(c) The applicable Contract Administrators;

(d) The Plan Administrator; and

(e) The delegates and designated agents of the individuals and entities listed in (a) through (d) above.

HIPAA.9 Company and Employer Functions.

Employment-Related Functions, Enrollment Activities and Premium Collection Activities are functions and activities that (a) are performed and rendered by the Company and the applicable Employers, (b) are not included in Plan Administration Functions and are not functions of the Plan, and (c) are not performed by any Fiduciary in their capacity as a Fiduciary to the Plan. Therefore, such functions are not subject to the requirements of the HIPAA Standards. If a Business Associate performs services that relate to eligibility and enrollment to the Plan, these services, to the extent permitted under HIPAA, shall be deemed to be performed on behalf of the Employer in its capacity as Plan Sponsor and not on behalf of the Plan.