



OAKTREE

Oaktree Capital Management, L.P. Benefit Plans

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Oaktree Capital Management, L.P. Benefit Plans

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OAKTREE

Health Plan

Summary Plan Description

Oaktree Capital Management, L.P. Health and Welfare Plan

Group No.: 12873

Summary Plan Description for Medical, Dental and Prescription Drug Benefits

Originally Effective: June 1, 1995

Amended and Restated Effective: January 1, 2013



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ESTABLISHMENT OF THE PLAN

Oaktree Capital Management, L.P. (the “Employer” or “Plan Sponsor”) has adopted this Summary Plan Description effective January 1, 2013 for the benefit program the Employer uses to provide its eligible Employees and their eligible Dependents with medical, dental and prescription drug benefits (the “Plan”). The Plan is part of the Oaktree Capital Management, L.P. Health and Welfare Plan. The Employer has the right to amend or terminate the Plan at any time.

Each Participating Employer, with the consent of the Plan Sponsor, has adopted this Summary Plan Description as of the effective date of the participation agreement by and between the Plan Sponsor and each Participating Employer.

Purpose of the Plan

The Plan Sponsor has established the Plan for your benefit and for the benefit of your eligible Dependents, on the terms and conditions described herein. The Plan Sponsor’s purpose in establishing the Plan and each Participating Employer’s purpose of adopting the Plan is to help to protect you and your family by offsetting some of the financial problems that may arise from an Injury or Illness. The Plan Administrator must abide by the terms of the Summary Plan Description and the Oaktree Capital Management, L.P. Health and Welfare Plan.

The Plan is not a contract of employment between you and your Employer or any Participating Employer and does not give you the right to be retained in the service of your Employer.

The purpose of this Plan is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain health care expenses. This Plan is maintained by the Plan Administrator and may be inspected at any time during normal working hours by you or your eligible Dependents.

Adoption of this Summary Plan Description

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Summary Plan Description (SPD) as the written description of the Plan. This SPD amends and replaces any prior statement of the health care coverage contained in any predecessor to the SPD.

GENERAL OVERVIEW OF THE PLAN

The Plan Administrator has entered into an agreement with Aetna PPO (the "Network"). This Network offers you health care services at discounted rates. Using a Network provider will normally result in a lower cost to the Plan as well as a lower cost to you. There is no requirement for any one to seek care from a provider who participates in the Network. The choice of provider is entirely up to you.

Covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level when a:

- (1) Covered Person has no choice of a Participating Provider.
- (2) Covered Person has an Emergency Medical Condition requiring immediate care.
- (3) Covered Person receives services by a Non-Participating Provider (e.g. anesthesiologists, radiologists, pathologists, etc.) who is under agreement with a Network facility.
- (4) Participating Provider is not available within a 30 radius of the Covered Person's residence.

Not all Physicians and Dentists based in Network Hospitals or medical facilities are Participating Providers. It is important when you enter a Hospital or medical facility that you request that ALL Physician services be performed by Participating Providers. By doing this, you will always receive the greater Participating Provider level of benefits.

A current list of Participating Providers is available, without charge, through the Third Party Administrator at www.myMERITAIN.com or you may use the Network website address listed on the Employee identification card. If you do not have access to a computer at your home, you may contact your Employer or the Network at the phone number on the Employee identification card to obtain a paper copy of the Participating Providers available.

You have a free choice of any provider, and you, together with your provider, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The Participating Providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any Participating Provider.

Costs

You must pay for a certain portion of the cost of Covered Expenses under the Plan, including (as applicable) any Copay, Deductible and Coinsurance percentage that is not paid by the Plan, up to the Out-of-Pocket Maximum set by the Plan.

Coinsurance

Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Coinsurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the Medical Schedule of Benefits.

There may be differences in the Coinsurance percentage payable by the Plan depending upon whether you are using a Participating Provider or a Non-Participating Provider. These payment levels are also shown in the Medical Schedule of Benefits.

Copay

A Copay is the portion of the medical expense that is your responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible, Coinsurance, or Out-of-Pocket Maximum.

Deductible

A Deductible is the total amount of eligible expenses as shown in the Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan. The family Deductible maximum, as shown in the Schedule of Benefits, is the maximum amount which must be Incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one (1) individual Deductible amount to a family Deductible.

If the medical Deductible is satisfied in whole or in part by eligible expenses Incurred during October, November or December, those expenses will also apply to the Deductible applicable in the next Calendar Year.

Out-of-Pocket Maximum

An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%. However, as noted below, there are certain expenses which are not counted in determining your Out-of-Pocket Maximum.

The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum, if applicable, is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied; however each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of covered expenses for any Covered Person in the family during the remainder of that Calendar Year.

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, ("non-accumulating expenses") include:

- (1) Copays, including Prescription Drug Copays
- (2) Deductibles
- (3) Precertification penalties
- (4) Charges over Usual and Customary Charges for Non-Participating Providers

Reimbursement for these non-accumulating expenses will continue at the percentage payable shown in the Medical Schedule of Benefits, subject to the Plan maximums.

The Plan will not reimburse any expense that is not an eligible expense. In addition, you must pay any expenses to which you have agreed that are in excess of the Usual and Customary Charges for Non-Participating Providers and any penalties for failure to comply with requirements of the Medical Management Program section of the Plan or any other penalty that is otherwise stated in this Plan. This could result in you having to pay a significant portion of your claim. None of these amounts will accumulate toward your Out-of-Pocket Maximum.

Once you have paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Calendar Year, the Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense, or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact your Plan Administrator for assistance.

Integration of Deductibles and Out-of-Pocket Maximums

If you use a combination of Participating Providers and Non-Participating Providers, your total Deductible amount and Out-of-Pocket Maximum amount required to be paid will not exceed the amount shown for Non-Participating Providers. In other words, the amount of the Deductible expense and Out-of-Pocket Maximum you pay for both Participating Providers and Non-Participating Providers will be combined, and the total will not exceed the amount shown for Non-Participating Providers during a single Calendar Year.

MEDICAL MANAGEMENT PROGRAM

You, your eligible Dependents or a representative acting on your behalf, must call the Medical Management Program Administrator to receive certification of Inpatient admissions (other than admissions for an Emergency Medical Condition), as well as other non-Emergency Services listed below. This call must be made at least 48 hours in advance of Inpatient admissions or receipt of the non-Emergency Services listed below. If the Inpatient admission is with respect to an Emergency Medical Condition, you must notify the Medical Management Program Administrator within 48 hours, or if later, by the next business day after the Emergency Medical Condition admission. Failure to obtain precertification or notify the Medical Management Program Administrator within the time frame indicated above may result in eligible expenses being reduced or denied. Please refer to the penalty section below.

Medical Management is a program designed to help ensure that you and your eligible Dependents receive necessary and appropriate healthcare while avoiding unnecessary expenses. The program consists of:

- (1) Precertification of Medical Necessity. The following items and/or services must be precertified before any medical services are provided:
 - (a) PPO 90 and PPO 100 Plans: Inpatient admissions, including inpatient admissions to a Skilled Nursing Facility, Extended Care Facility, Rehabilitation Facility, and inpatient admissions due to a Mental Disorder or Substance Use Disorder; and transplants (including travel and lodging)
 - (b) PPO 90 Plan: the following surgical procedures: cholecystectomy; prostate surgery; hysterectomy; thyroidectomy; laminectomy; tonsillectomy; Marshall-Marchetti-Krantz; transplants (except kidney and cornea); mastectomy; varicose vein surgery
- (2) Concurrent Review for continued length of stay and assistance with discharge planning activities.
- (3) Retrospective review for Medical Necessity where precertification is not obtained or the Medical Management Program Administrator is not notified.

Medical Management Does Not Guarantee Payment. All benefits/payments are subject to the patient's eligibility for benefits under the Plan. For benefit payment, services rendered must be considered an eligible expense under the Plan and are subject to all other provisions of the Plan.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other healthcare provider.

How the Program Works

Precertification

Before you or your eligible Dependents are admitted to a medical facility or receive items or services that require precertification on a non-Emergency Medical Condition basis (that is an Emergency Medical Condition is not involved), the Medical Management Program Administrator will, based on clinical information from the provider or facility, certify the care according to the Medical Management Program Administrator's policies and procedures.

The Medical Management Program is set in motion by a telephone call from you, the patient, or a representative acting on your behalf or on behalf of the patient.

To allow for adequate processing of the request, contact the Medical Management Program Administrator at least 48 hours before receiving any item or service that requires precertification or an Inpatient admission for a Non-Emergency Medical Condition with the following information:

- (1) Name, identification number and date of birth of the patient;
- (2) The relationship of the patient to the covered Employee;

- (3) Name, identification number, address and telephone number of the covered Employee;
- (4) Name of Employer and group number;
- (5) Name, address, Tax ID #, and telephone number of the admitting Physician;
- (6) Name, address, Tax ID #, and telephone number of the medical facility with the proposed date of admission and proposed length of stay;
- (7) Proposed treatment plan; and
- (8) Diagnosis and/or admitting diagnosis.

If there is an Inpatient admission with respect to an Emergency Medical Condition, you, the patient, or a representative acting on your behalf or on behalf of the patient, including, but not limited to, the Hospital or admitting Physician, must contact the Medical Management Program Administrator within 48 hours after the start of the confinement or on the next business day, whichever is later.

Hospital stays in connection with childbirth for either the mother or newborn may not be less than 48 hours following a vaginal delivery, or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother.

You, the patient, and the providers are NOT REQUIRED to obtain precertification for a maternity delivery admission, unless the stay extends past the applicable 48- or 96-hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified with the Medical Management Program Administrator or a penalty will be applied.

The Medical Management Program Administrator, in coordination with the facility and/or provider, will make a determination on the number of days certified based on the Medical Management Program Administrator's policies, procedures and guidelines. If the confinement will last longer than the number of days certified, a representative of the Physician or the facility must call the Medical Management Program Administrator before those extra days begin and obtain certification for the additional time. If the additional days are not requested and certified, room and board expenses will not be payable for any days beyond those certified.

If the patient does not obtain precertification for their Inpatient admission at least 48 hours in advance of the admission, or notify the Medical Management Program Administrator within 48 hours after an Emergency Medical Condition admission, or if precertification is obtained or notification received outside the time frames specified, eligible expenses may be reduced or denied. Please refer to the penalty section below.

Penalty

If you fail to obtain precertification or fail to notify the Medical Management Program Administrator within the time periods described above, benefits under the Plan will be reduced as follows:

- (1) PPO 100 Plan: Covered Expenses will be reduced by 25% per occurrence and this penalty amount will not accumulate toward any Out-of-Pocket Maximum limit.
- (2) PPO 90 Plan: Covered Expenses will be reduced by 25% to a maximum of \$2,000 per Calendar Year and this penalty amount will not accumulate toward any Out-of-Pocket Maximum limit.

If the Plan's required review procedures are not followed, a retrospective review will be conducted by the Medical Management Program Administrator to determine if the services provided met all other Plan provisions and requirements. If the review concludes the services were Medically Necessary and would have been approved had the required phone call been made, benefits will be considered, subject to the penalty outlined above. However, any charges not deemed Medically Necessary will be denied.

Concurrent Review, Discharge Planning

Discharge planning needs is part of the Medical Management Program. The Medical Management Program Administrator will assist and coordinate the initial implementation of any services the patient will need post hospitalization with the attending Physician and the facility. If the attending Physician feels that it is Medically Necessary for a patient to stay in the medical care facility for a greater length of time than has been precertified, the attending Physician or the medical facility must request the additional service or days.

Concurrent Inpatient Review

Once the Inpatient setting has been precertified, the on-going review of the course of treatment becomes the focus of the program. Working directly with your Physician, the Medical Management Program Administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

To File a Complaint or Request an Appeal to a Non-Certification

Verbal appeal requests and information regarding the appeal process should be directed to the Medical Management Program Administrator as identified on the General Information page of this Plan.

Case Management

When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the patient's condition is diagnosed, the patient might need extensive services or might be able to be moved into another type of care setting, even to the patient's home.

Case management is a program whereby a Case Manager contacts the patient to obtain consent for case management services. The Case Manager monitors the patient and explores, discusses and recommends coordinated and/or alternate types of appropriate medical care. The Case Manager consults with the patient, family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient.

This plan of care may include some or all of the following:

- (1) Personal support to the patient;
- (2) Contacting the family to offer assistance and support;
- (3) Monitoring Hospital or skilled nursing care or home health care;
- (4) Determining alternative care options; and
- (5) Assisting in obtaining any necessary equipment and services.

Case management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The Case Manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan staff, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Medical Management will not interfere with your course of treatment or the Physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program.

The Medical Management Program Administrator contact information for this Plan is identified on the Employee identification card and also on the General Information page of this Plan.

MEDICAL SCHEDULE OF BENEFITS - PPO 90 PLAN

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single	\$100	\$100
Family	\$300	\$300
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (excludes Deductible)		
Single	\$500	\$1,000
Family	\$1,500	\$3,000
The Plan has a Pre-Existing Condition limitation. Please refer to the Pre-Existing Condition Limitation section for further details regarding coverage limitations and provisions for Creditable Coverage. This provision does not apply to any Covered Person under the age of 19.		
MEDICAL BENEFITS		
Accident Benefit (within 90 days of Accident)	100% of the first \$500 per accident, then same as any other Illness	100% of the first \$500 per accident, then same as any other Illness
Acupuncture	80% after Deductible	80% after Deductible
Allergy Serums and Injections	90% after Deductible	70% after Deductible
Ambulance Services	90% after Deductible	Paid at Participating Provider level of benefits
Ambulatory Surgical Center	90% after Deductible	70% after Deductible
Birthing Center	100%; Deductible waived	70% after Deductible
Chiropractic Care/Spinal Manipulation	90% after Deductible	70% after Deductible
Diagnostic Testing, X-ray and Lab Services (Office/Clinic Services)	90% after Deductible	70% after Deductible
Lab Card Services (Outpatient)	100%; Deductible waived	Not Applicable
The use of the Lab Card program offered by Quest Diagnostics is strictly voluntary. If a Covered Person uses the services of Lab Card, the Plan will pay 100% of the eligible charges a Covered Person incurs for outpatient laboratory services, and will waive any of this Plan's Copays, Deductibles and/or Coinsurance requirements. If a Covered Person and/or a Physician elect to use another lab – including the lab in the Physician's office – normal Plan benefits will apply. See the Diagnostic Testing, X-ray and Laboratory Services benefit under Eligible Medical Expenses for further details of this program.		
Durable Medical Equipment (DME)	90% after Deductible	70% after Deductible
Emergency Services – Emergency Medical Condition	100%; Deductible waived	100%; Deductible waived*
*Paid at Participating Provider level of benefits unless otherwise required by law.		

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Emergency Room Services - Non-Emergency Medical Condition	90% after Deductible	70% after Deductible
Home Health Care	100%; Deductible waived	70% after Deductible
Calendar Year Maximum Benefit	100 visits	
Hospice Care	100%; Deductible waived	70% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	90% after Deductible	70% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*
Intensive Care Unit	90% after Deductible ICU/CCU Room rate	70% after Deductible ICU/CCU Room rate
Miscellaneous Services & Supplies	90% after Deductible	70% after Deductible
Outpatient	90% after Deductible	70% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Maternity (Professional Fees)*		
Preventive prenatal and breastfeeding support (other than lactation consultations)	100%; Deductible waived	70% after Deductible
Lactation consultations	100%; Deductible waived	100%; Deductible waived
All other prenatal and postnatal care	90% after Deductible	70% after Deductible
Delivery	90% after Deductible	70% after Deductible
*See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	90% after Deductible	70% after Deductible
Outpatient	90% after Deductible	70% after Deductible
Emergency Care	100%; Deductible waived 100%; Deductible waived	100%; Deductible waived* 100%; Deductible waived*
Ambulance		
Emergency Services		
*Paid at Participating Provider level of benefits unless otherwise required by law.		
Outpatient Therapies (e.g., physical, speech, occupational, hearing)	90% after Deductible	70% after Deductible
Physician's Services		
Inpatient/Outpatient Services	90% after Deductible	70% after Deductible
Office Visits	90% after Deductible	70% after Deductible
Physician Office Surgery	90% after Deductible	70% after Deductible
Pre-Admission Testing (Outpatient) (performed within 7 days of a scheduled Inpatient admission)	100%; Deductible waived	70% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Preventive Services		
Preventive Services Under Health Care Reform (includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	100%; Deductible waived	70% after Deductible
Other Preventive Services Includes but is not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or inoculations (including pre-travel and Visa related), well child care, pap smears, mammograms (includes computer assisted diagnosis mammography), colon exams, PSA testing, bone density, CA125, CBC, chest x-ray, complete metabolic panel, CRP, echocardiogram, ferritin, Gardasil, hematology, hepatic panel, iron/TIBC lipid profile, pulmonary function test, routine EKG/ECG, gynecological exams, sigmoidoscopies, sedimentation rate, SMAC-19, T3, TSH, uric acid, ultrasound for breast cancer screening, and vitamin B-12. If a diagnosis is indicated after a preventive exam, the exam will still be payable under the preventive services benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other illness. This benefit is in addition to coverage under the Preventive Services Under Health Care Reform section of the Plan.	100%; Deductible waived	70% after Deductible
Prosthetics	90% after Deductible	70% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	100%; Deductible waived	70% after Deductible
Combined Calendar Year Maximum Benefit	90 days	
Temporomandibular Joint Dysfunction (TMJ)	90% after Deductible	70% after Deductible
Transplants	100%; Deductible waived (Aetna IOE Facility)* 70% after Deductible (non-Aetna IOE Facility)	70% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) section of this Plan for a more detailed description of this benefit.		
Urgent Care Facility	90% after Deductible	70% after Deductible
All Other Eligible Medical Expenses	90% after Deductible	70% after Deductible

MEDICAL SCHEDULE OF BENEFITS - PPO 100 PLAN

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single	None	\$200
Family	None	\$600
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (excludes deductible)		
Single	None	\$10,000
Family	None	\$30,000
The Plan has a Pre-Existing Condition limitation. Please refer to the Pre-Existing Condition Limitation section for further details regarding coverage limitations and provisions for Creditable Coverage. This provision does not apply to any Covered Person under the age of 19.		
MEDICAL BENEFITS		
Accident Benefit (within 90 days of Accident)	100% of the first \$500 per accident, then same as any other Illness	100% of the first \$500 per accident, then same as any other Illness
Acupuncture	80%	80% after Deductible
Allergy Serums and Injections	100%	50% after Deductible
Ambulance Services	100%	100%; Deductible waived
Ambulatory Surgical Center	100%	50% after Deductible
Birthing Center	100%	50% after Deductible
Chiropractic Care/Spinal Manipulation	100%	50% after Deductible
Diagnostic Testing, X-ray and Lab Services (Office/Clinic Services)	\$10 Copay, then 100%	50% after Deductible
Lab Card Services (Outpatient)	100%	Not Applicable
The use of the Lab Card program offered by Quest Diagnostics is strictly voluntary. If a Covered Person uses the services of Lab Card, the Plan will pay 100% of the eligible charges a Covered Person incurs for outpatient laboratory services, and will waive any of this Plan's Copays and/or Coinsurance requirements. If a Covered Person and/or a Physician elect to use another lab – including the lab in the Physician's office – normal Plan benefits will apply. See the Diagnostic Testing, X-ray and Laboratory Services benefit under Eligible Medical Expenses for further details of this program.		
Durable Medical Equipment (DME)	100%	50% after Deductible
Emergency Services – Emergency Medical Condition	100%	100%; Deductible waived*
*Paid at Participating Provider level of benefits unless otherwise required by law.		

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Emergency Services - Non-Emergency Medical Condition	\$25 Copay, then 100%	50% after Deductible
NOTE: The Emergency Services Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Home Health Care	100%	50% after Deductible
Calendar Year Maximum Benefit	100 visits	
Hospice Care	100%	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	100%	\$250 Copay, then Deductible, then 50%
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*
Intensive Care Unit	100% ICU/CCU Room rate	\$250 Copay, then Deductible, then 50% ICU/CCU Room rate
Miscellaneous Services & Supplies	100%	50% after Deductible
Outpatient	100%	50% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Maternity (Professional Fees)*		
Preventive prenatal and breastfeeding support (other than lactation consultations)	100%	50% after Deductible
Lactation consultations	100%	100%; Deductible waived
All other prenatal and postnatal care	100%	50% after Deductible
Delivery	100%	50% after Deductible
*See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	100%	\$250 Copay, then Deductible, then 50%
Outpatient		
Office Visits	\$10 Copay, then 100%	50% after Deductible
All Other Items and Services	100%	50% after Deductible
Emergency Care		
Ambulance	100%	100%; Deductible waived*
Emergency Services	100%	100%; Deductible waived*
*Paid at Participating Provider level of benefits unless otherwise required by law.		
Outpatient Therapies (e.g., physical, speech, occupational, hearing)	\$10 Copay, then 100%	50% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physician's Services		
Inpatient/Outpatient Services	100%	50% after Deductible
Office Visits	\$10 Copay, then 100%	50% after Deductible
Specialist Visits	\$20 Copay, then 100%	50% after Deductible
Physician Office Surgery	100%	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
Pre-Admission Testing (Outpatient) (performed within 7 days of a scheduled Inpatient admission – if performed in a Physician's office, the office visit Copay will apply)	100%	50% after Deductible
Preventive Services		
Preventive Services Under Health Care Reform (includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	100%	50% after Deductible
Other Preventive Services Includes but is not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or inoculations (including pre-travel and Visa related), well child care, pap smears, mammograms (includes computer assisted diagnosis mammography), colon exams, PSA testing, bone density, CA125, CBC, chest x-ray, complete metabolic panel, CRP, echocardiogram, ferritin, Gardasil, hematology, hepatic panel, iron/TIBC lipid profile, pulmonary function test, routine EKG/ECG, gynecological exams, sigmoidoscopies, sedimentation rate, SMAC-19, T3, TSH, uric acid, ultrasound for breast cancer screening, and vitamin B-12. If a diagnosis is indicated after a preventive exam, the exam will still be payable under the preventive services benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other illness. This benefit is in addition to coverage under the Preventive Services Under Health Care Reform section of the Plan.	100%	50% after Deductible
Prosthetics	100%	50% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	100%	50% after Deductible
Combined Calendar Year Maximum Benefit	90 days	

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Temporomandibular Joint Dysfunction (TMJ)	\$10 Copay, then 100%	50% after Deductible
Transplants	100% (Aetna IOE Facility)* 50% (non-Aetna IOE Facility)	50% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) section of this Plan for a more detailed description of this benefit.		
Urgent Care Facility	\$10 Copay, then 100%	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
All Other Eligible Medical Expenses	100%	50% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – ALL PLANS

BENEFIT DESCRIPTION	BENEFIT
Retail Pharmacy: 30-day supply	
Generic Drug	\$5 Copay, then 100%
Brand Name Drug	\$15 Copay, then 100%
Specialty Drug	\$25 Copay, then 100%
Preventive Drug	\$0 Copay (Paid at 100%)
Retail Pharmacy: 90-day supply (Caremark network pharmacies only)	
Generic Drug	\$15 Copay, then 100%
Brand Name Drug	\$45 Copay, then 100%
Specialty Drug	\$75 Copay, then 100%
Preventive Drug	\$0 Copay (Paid at 100%)
Mail Order Pharmacy: 90-day supply	
Generic Drug	\$5 Copay, then 100%
Brand Name Drug	\$10 Copay, then 100%
Specialty Drug	\$25 Copay, then 100%
Preventive Drug	\$0 Copay (Paid at 100%)

Dispense As Written (DAW)

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Brand Name drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Brand Name Drug in addition to the Brand Name Drug Copay. The Covered Person's share of the Prescription Drug cost does not apply toward the Plan's Out-of-Pocket Maximum.

Specialty Pharmacy Program

Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs must be obtained directly from a CVS Pharmacy. For additional information, please contact the Prescription Drug Card Program Manager.

DENTAL SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT
PRE-DETERMINATION LIMIT	\$300
CALENDAR YEAR DEDUCTIBLE	
Single	\$50
Family	\$150
CLASS A, B AND C EXPENSES COMBINED CALENDAR YEAR MAXIMUM BENEFIT	\$2,000 per Covered Person
CLASS D ORTHODONTIC LIFETIME MAXIMUM BENEFIT	\$1,000 per Covered Person
DENTAL BENEFITS	
Class A-Preventive Services	100%; Deductible waived
Class B-Basic Services	80% after Deductible
Class C-Major Services	50% after Deductible
Class D-Orthodontic Services	50%; Deductible waived

NOTE: *The dental benefits provided under this Plan are limited-scope benefits and are offered separately from any medical coverage offered under the Plan. You have a separate right to enroll in the dental benefits under the Plan. If you choose to enroll in such dental benefit, you will be charged an employee contribution amount that is separate from what you are charged for any other benefit offered under the Plan. The amount of any employee contribution will be communicated to you by the Plan Administrator.*

PRE-EXISTING CONDITION LIMITATION

A Pre-Existing Condition Limitation applies to all Employees and Dependents age 19 and older. A Pre-Existing Condition is defined as an Illness or Injury, regardless of cause, for which medical advice, diagnosis, care, or treatment was recommended or received during the three (3) month period prior to the individual's Enrollment Date.

No coverage is provided for expenses in connection with a Pre-Existing Condition.

Full Plan coverage will be available for such condition(s) on the day immediately following the expiration of 12 months or, in the case of a Late Enrollee, 18 months after your Enrollment Date. You have the right to demonstrate any Creditable Coverage, and the applicable period will be reduced by any Creditable Coverage unless it occurred before a Significant Break in Coverage.

The Pre-Existing Condition Limitation does not apply to:

- (1) Maternity benefits.
- (2) An Employee or Dependent under age 19.
- (3) Genetic Information provided there has been no diagnosis of a condition related to the Genetic Information.
- (4) Prescription Drugs purchased through the Prescription Drug Card program.

The length of the Pre-existing Condition Limitation may be reduced or eliminated if a Covered Person has Creditable Coverage, provided there was not a Significant Break in Coverage. A Covered Person may request a Certificate of Creditable Coverage from their prior plan within 24 months of losing coverage. Certificates of Creditable Coverage should be submitted to the Plan Administrator and appropriate credit for time covered will be applied to the Pre-Existing Condition Limitation. A determination letter will be sent to the Covered Person, advising of the credit applied to any Pre-Existing Condition Limitation. The determination letter will also include an explanation of the Plan's appeals procedures and give you a reasonable opportunity to present additional evidence.

All questions about the Pre-Existing Condition limitation and Creditable Coverage should be directed to the Plan Administrator as identified in the General Information section of the Plan.

Certificates of Creditable Coverage

The Plan generally will automatically provide a Certificate of Creditable Coverage to anyone who loses coverage under the Plan. In addition, a Certificate of Creditable Coverage will be provided upon request at any time while the individual is covered under the Plan and up to 24 months after the individual loses coverage under the Plan.

The Plan will make reasonable efforts to collect information applicable to any Dependents and to include that information on the Certificate of Creditable Coverage, but the Plan will not issue an automatic Certificate of Creditable Coverage for Dependents until the Plan has reason to know that a Dependent has lost coverage under the Plan.

All questions about the Certificate of Creditable Coverage may be directed to the Plan Administrator. Refer to the General Information page.

ELIGIBILITY FOR PARTICIPATION

Employee Eligibility

An Employee includes a partner of an Employer who provides services to such Employer. A full-time or part-time Employee of the Employer who regularly works 25 or more hours per week for an Employer or a Participating Employer will be eligible to enroll for coverage under this Plan as of his/her first date of employment. Participation in the Plan will begin as of the first day of the month coinciding with or next following his or her first date of employment, provided all required election and enrollment forms are properly submitted to the Plan Administrator.

You are not eligible to participate in the Plan if you are a temporary, leased or seasonal employee, an independent contractor, or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency).

Your Dependents are eligible for participation in this Plan; provided he/she is:

- (1) Your Spouse.
- (2) Your Domestic Partner.
- (3) Your Child until the end of the month in which he/she attains age 26.
- (4) Your Child age 26 or older, who is unable to be self supporting by reason of mental or physical handicap and is incapacitated, provided the child suffered such incapacity prior to the end of the month in which he/she attained age 26. Your Child must be unmarried, primarily dependent upon you for support, reside with you for more than one-half of the Calendar Year, and not eligible for any other type of health coverage (other than Medicaid or Medicare). The Plan Sponsor may require subsequent proof of your Child's disability and dependency, including a Physician's statement certifying your Child's physical or mental incapacity.
- (5) A child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Plan Administrator at no cost.

The below terms have the following meanings:

"Child" means your natural born son, daughter, stepson, stepdaughter, legally adopted child (or a child placed with you in anticipation of adoption), Eligible Foster Child or a child for whom you are the Legal Guardian. Coverage for an Eligible Foster Child or a child for whom you are the Legal Guardian will remain in effect until such child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such child has attained age 18 (or any other applicable age of emancipation of minors). The term "Child" shall include a child of your Domestic Partner.

"Child placed with you in anticipation of adoption" means a child that you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

"Domestic Partner" means an unrelated individual of the same or opposite sex for which an Employee submits an affidavit of domestic partnership to the Employer. The affidavit must include the following statements:

- (1) Both partners are at least 18 years of age.
- (2) Each partner is the other's sole Domestic Partner.
- (3) Neither partner is legally married to anyone.

- (4) The partners are not related by blood closer than would bar marriage in the state in which they live.
- (5) Both partners are legally competent to enter into a contract.
- (6) The partners have jointly shared the same regular and permanent residence for at least six (6) months immediately preceding the date of the Affidavit with the intent to continue doing so indefinitely.
- (7) The partners are jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household. Domestic Partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost. If requested, the partners would be able to provide evidence of at least three (3) of the following as proof of joint responsibility.

Examples of documentation that would meet this requirement include, but are not limited to: joint mortgage or lease, designation of the Domestic Partner as primary beneficiary for a life insurance or a retirement contract, designation of the Domestic Partner as primary beneficiary in the Employee's will, a Durable Power of Attorney for health care or financial management, and/or joint ownership of a motor vehicle, a joint checking account, or a joint credit account (information should be dated to confirm eligibility at time of enrollment).

The Plan Administrator reserves the right to require such evidence as it deems necessary that a Domestic Partner satisfies the above eligibility requirements.

"Eligible Foster Child" shall mean an individual who is placed with you by an authorized placement agency.

"Legal Guardian" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual that is placed with such person by judgment, decree, or other order of any court of competent jurisdiction.

"Spouse" means a person of the same or opposite sex recognized as the covered Employee's husband or wife who are legally married. Specifically excluded from this definition is a spouse by reason of common law marriage, whether or not permitted in your State. The Plan Administrator may require documentation proving a legal marital relationship.

When both you and your Spouse are covered Employees, each of you must choose coverage as either an Employee or as a Dependent. You may not be covered under this Plan as both an Employee and a Dependent.

Court Ordered Coverage for a Child

Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below.

The Plan Administrator shall enroll for immediate coverage under this Plan any Child, who is the subject of a "qualified medical child support order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Plan Administrator receives a QMCSO, the Plan Administrator shall also enroll you for immediate coverage under this Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Administrator determines that the order is a QMCSO. Any required contribution for coverage pursuant to this section will be deducted from your pay in accordance with the Plan Sponsor's or Participating Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your child and includes certain information concerning such coverage. The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no child is eligible for Plan coverage, even if you are required to provide coverage for that child under the terms of a separation agreement or court order, unless the child is an eligible Child under this Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Plan Administrator.

Timely Enrollment

Once you are eligible to participate in the Plan, you must enroll for coverage by completing all election and enrollment forms and submitting them to your Human Resources Department within 31 days after satisfaction of the eligibility requirements. If you are required to contribute towards the cost of coverage you must complete and submit a payroll deduction authorization for the Plan Administrator to deduct the required contribution from your pay. In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your Dependents. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

Coverage under the Plan is subject to a Pre-Existing Condition Limitation. Please refer to the section entitled "Pre-Existing Condition Limitation" for more information.

If you decline enrollment for you and/or your Dependents, because you or your Dependents had no other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution or a medical care program of the Indian Health Service or of a tribal organization), you must provide a written statement to your Human Resources Department indicating that the reason you are declining enrollment is due to other health coverage. If you lose such other health coverage, it may constitute a Special Enrollment Event (described below) that gives you and/or your Dependents a right to enroll in the Plan mid-year due to such loss of coverage. However, if you failed to submit such written statement when initially eligible, you will lose your right to this special mid-year enrollment opportunity.

If you fail to complete and submit the appropriate election and enrollment forms within the 31-day period described above, you will not be eligible to enroll in the Plan until the next open enrollment period or unless you experience a Special Enrollment Event or a Status Change Event.

Open Enrollment Period

You and your Dependents may enroll for coverage during the Plan's open enrollment period, designated by the Plan Sponsor and communicated to you prior to such open enrollment period. During this time you will be permitted to make changes to any existing benefit elections. Benefit elections made during the open enrollment period will be effective as of January 1 and will remain in effect until the next open enrollment period unless you experience or your Dependent experiences a Special Enrollment Event or Status Change Event.

Special Enrollment Event

A special enrollment event occurs when you or your Dependents suffer a loss of other health care coverage, when you become eligible for a state premium assistance subsidy, or acquire a new Dependent as a result of marriage, establishment of a Domestic Partner relationship, birth, adoption or placement for adoption. In these circumstances, you and/or your eligible Dependents will be considered Special Enrollees.

Special Enrollees are subject to the Plan's Pre-Existing Condition Limitation. Please refer to the section entitled "Pre-Existing Condition Limitation" for more information.

Each special enrollment event is more fully described below:

- (1) **Loss of Other Coverage (other than under Medicaid or SCHIP).** If you declined enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll for coverage for yourself and/or your Dependents under this Plan if the other health coverage is lost as a result of one of the following; provided, however, you submitted a written statement to your Human Resources Department when you and/or your Dependents were initially eligible stating that other health coverage was the reason for declining enrollment under this Plan:
 - (a) The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;

- (b) Loss of eligibility under the other health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim, or intentional misrepresentation of a material fact in connection with the other plan; or
- (c) Employer contributions cease for the other health coverage.

If you are already enrolled in a benefit option available under the Plan and your Dependent lost his or her other health coverage, you may enroll in a different benefit option available under the Plan due to the special enrollment event of your Dependent.

You must submit the appropriate election and enrollment forms to your Human Resources Department within 31 days after the date the other health coverage was lost. Coverage under the Plan will become effective on the first day of the month coinciding with or immediately following the date you submit the appropriate election and enrollment forms to your Human Resources Department.

- (2) **Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy.** If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a State sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates or you or your Dependents are no longer eligible for Medicaid or SCHIP or you or your Dependents become eligible for a State premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Plan for yourself and your Dependents after Medicaid or SCHIP coverage terminates or after you or your Dependents' eligibility for a State assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms to your Human Resources Department within 60 days after coverage under Medicaid or CHIP terminates or within 60 days after eligibility for a State premium assistance subsidy under Medicaid or CHIP is determined. Coverage under the Plan will become effective on the first day of the month coinciding with or immediately following the date you submit the appropriate election and enrollment forms to your Human Resources Department. Coverage under the Plan will become effective on the first day of the month coinciding with or immediately following the date you submit the appropriate election and enrollment forms to your Human Resources Department.

- (3) **Acquisition of a New Dependent.** If you acquire a new Dependent as a result of marriage, establishment of a Domestic Partner relationship, birth, adoption, or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your Dependents. You must submit the appropriate election and enrollment forms to your Human Resources Department within 31 days after the date you acquire such Dependent.

- (a) Coverage becomes effective for a Dependent Child who is born after the date your coverage becomes effective as of such child's date of birth and will continue for the first 31 days after birth. If you wish to continue coverage beyond this 31-day period, you must complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 31 days after the child's birth. Failure to enroll in the Plan within the 31-day period described above will result in no coverage under the Plan beyond the first 31 days after the child's birth.
- (b) Coverage for a newly acquired Dependent due to marriage or establishment of a Domestic Partner relationship will be effective on the date of marriage or establishment of a Domestic Partner relationship; provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 31 days after your date of marriage or establishment of a Domestic Partner relationship. The Pre-Existing Condition Limitation does not apply to any newly acquired Dependent under age 19. Failure to enroll in the Plan within the 31-day period described above will result in no coverage under the Plan.
- (c) Coverage for a newly acquired Dependent due to adoption (or placement with you in anticipation of adoption) will be effective as of the date of adoption (or placement in anticipation of adoption); provided you complete and submit the required election and enrollment forms (including a payroll deduction

authorization, if applicable) within 31 days after adoption or placement in anticipation of adoption, as applicable. Failure to enroll in the Plan within the 31-day period described above will result in no coverage under the Plan.

Status Change Event

Generally your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event (described above) or a Status Change Event. If a Status Change Event occurs you may make a new election under the Plan; provided your new election is consistent with the Status Change Event. A Status Change Event includes the following:

- (1) A change in your legal marital status, including divorce, legal separation, annulment or termination of a Domestic Partner relationship;
- (2) The death of your Spouse, Domestic Partner or Dependent Child;
- (3) Termination or commencement of employment by you, your Spouse, your Domestic Partner or your Dependent Child that results in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;
- (4) A reduction or increase in your hours of employment, or those of your Spouse, your Domestic Partner or your Dependent Child, including a switch from part-time to full-time, or commencement or return from an unpaid leave of absence, resulting in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;
- (5) A change due to your Dependent Child satisfying or ceasing to satisfy the requirements for Dependents under the Plan;
- (6) A change in the place of residence or work of you, your Spouse, your Domestic Partner or your Dependent Child;
- (7) Entitlement to or loss of entitlement to Medicare or Medicaid by you, your Spouse, your Domestic Partner or your Dependent Child;
- (8) Receipt of a Qualified Medical Child Support Order ("QMCSO") which requires that you provide the child named in the Order with health care coverage under the Plan. If the required coverage is different from your current coverage under the Plan, you may change your election accordingly;
- (9) A change due to you, your Spouse, your Domestic Partner or your Dependent Child gaining coverage under another employer's plan;
- (10) A significant increase in the cost of your coverage under the Plan during the Plan Year. If the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose one of the following options: (a) maintain existing coverage and agree to pay the increased cost; (b) revoke your existing election and elect similar coverage under another Plan option (if any); or (c) drop coverage under the Plan, but only if there is no similar option available under the Plan;
- (11) Addition or significant improvement of a Plan option. If the Plan adds a new option or significantly improves an existing option, you may revoke your existing election and elect coverage under the new option. Any eligible Employee, regardless of whether or not he/she elected coverage under the Plan previously, may elect coverage under any new option or significantly improved option for himself or herself and any eligible Dependents;
- (12) Significant Curtailment of Coverage without Loss. If your coverage under the Plan is significantly curtailed without a loss of coverage (for example, a significant increase is the Out-of-Pocket maximum you are required to pay), you may revoke your existing election under the Plan and elect coverage under a similar Plan option, if any. If no similar option is available, then you must maintain your existing election until the end of the current Plan Year;

- (13) Significant Curtailment of Coverage with Loss. If your coverage under the Plan is significantly curtailed with a loss of coverage (for example, elimination of a benefit option under the Plan), then you may either revoke your existing election under the Plan and elect coverage under a similar Plan option (if any) or drop your existing coverage, provided there is no similar Plan option available; and
- (14) Change in Election under another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including another plan maintained by the Employer or a plan maintained by the employer of your Spouse, your Domestic Partner or Dependent Child); provided the election change satisfied the regulations under Code Section 125 regarding permitted election changes, or the election is for a period of coverage under the plan maintained by the other employer which does not correspond to the Plan Year of this Plan.

You must submit the appropriate election and enrollment forms to your Human Resources Department within 31 days after the Status Change Event. Coverage under the Plan will become effective on the first day of the month coinciding with or immediately following the date you submit the appropriate election and enrollment forms to your Human Resources Department.

TERMINATION OF COVERAGE

Termination of Employee Coverage

Coverage under the Plan will terminate on the earliest of the following dates:

- (1) The date the Plan terminates, in whole or in part;
- (2) If you fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;
- (3) The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained below;
- (4) The end of the month in which you cease to be eligible for coverage under the Plan;
- (5) The end of the month in which you terminate employment or cease to be included in an eligible class of Employees;
- (6) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; and
- (7) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

Termination of Dependent Coverage

Coverage under the Plan will terminate on the earliest of the following dates:

- (1) The date the Plan terminates, in whole or in part;
- (2) The date the Plan discontinues coverage for Dependents;
- (3) The date your Dependent becomes eligible as an Employee under the Plan;
- (4) The date coverage terminates for the Covered Employee;
- (5) If you and/or your Dependents fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;
- (6) The end of the month the Dependent Spouse or Domestic Partner reports to active military service;
- (7) The end of the month in which a Dependent ceases to be a Dependent as defined by the Plan;
- (8) The date your Dependent (or any person seeking coverage on behalf of your Dependent) performs an act, practice or omission that constitutes fraud; and
- (9) The date your Dependent (or any person seeking coverage on behalf of your Dependent) makes an intentional misrepresentation of a material fact.

Retroactive Termination of Coverage

Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice, or omission that constitutes fraud with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above,

coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

Continuation of Plan Coverage due to Layoff, Disability or an Approved Leave of Absence

Medical and dental coverage will be continued by your Employer or Participating Employer for you and your Dependents in the event of layoff, disability or an approved leave of absence. Coverage will continue as follows:

- (1) In the event of a layoff, 31 days following the date of layoff.
- (2) In the event of Disability, 90 days following the last day of active employment.
- (3) In the event of an approved leave of absence, your coverage will continue for 31 days.

If your leave qualifies under the Family and Medical Leave Act (FMLA), any continuation of coverage provided under this provision will not run concurrent with FMLA. Any continuations above that qualify as FMLA will first be considered as FMLA, then the eligible disability or leave of absence continuation periods specified above, then COBRA.

Coverage under this provision will continue in accordance with the same terms and conditions of an active Employee and any period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under COBRA. Please refer to the COBRA Continuation Coverage section of the Plan.

Continuation of Coverage under the Family and Medical Leave Act (FMLA)

The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended and as promulgated in regulations issued by the Department of Labor. Continuation of coverage while on FMLA will be separate from and in addition to COBRA continuation.

During any leave taken under the FMLA, you may maintain coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during the leave period. Failure to make required payments within 30 days of the due date established by the Plan Sponsor or Participating Employer will result in the termination of coverage for you and/or your eligible Dependents.

If you fail to return to work after the FMLA leave, the Employer may have the right to recover its contributions toward the cost of coverage during the FMLA leave.

If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated for you and your covered Dependents if you return to work at the end of the FMLA leave.

Continuation of Coverage under State Family and Medical Leave Laws

To the extent this Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

Continuation of Coverage under USERRA

You may elect to continue Plan coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if you are absent from work due to military service in the Uniformed Services (as defined under USERRA). You may elect to continue coverage for yourself and any of your Dependents that were covered under the Plan at the time of your leave. Your eligible Dependents do not have an independent right to elect coverage under USERRA; therefore unless you elect to continue coverage on their behalf, your eligible Dependents will not be permitted to continue coverage under USERRA separately.

To elect coverage under USERRA, you must submit your election to continue coverage under USERRA, on a form prescribed by the Plan Administrator to your Human Resources Department within 60 days after the date of your leave. Coverage under the Plan will become effective as of the date of your leave and will continue for the lesser of (a) 24 months (beginning on the date your absence begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Plan Sponsor or

Participating Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA.

If your leave is 31 days or more, you will be required to pay up to 102% of the full contribution under the Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you remained an active Employee of the Plan Sponsor or Participating Employer. The Plan Sponsor or your Participating Employer will notify you of the procedures for making payments under this Plan.

Continuation coverage provided under USERRA counts towards the maximum coverage period under COBRA continuation coverage.

An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period or pre-existing condition exclusionary period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period or exclusionary period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

SURVIVOR BENEFIT

Survivor Benefit for Employees

In the event of death of an Employee, coverage will continue for the Spouse and any eligible Dependents until the earlier of the following:

- (1) The date the Dependent fails to satisfy the eligibility requirements for coverage under the Plan.
- (2) Six (6) months following the date of the Employee's death.

If coverage under the Plan is subject to COBRA, this continuation period will be separate from and is in addition to COBRA continuation.

ELIGIBLE MEDICAL EXPENSES

Eligible expenses shall be the charges actually made for services provided to the Covered Person and will be considered eligible only if the expenses are:

- (1) Preventive services provided such services are ordered and performed by a Physician and not otherwise excluded under the Plan; or
- (2) Due to Illness or Injury; provided such services are ordered and performed by a Physician, Medically Necessary and not otherwise excluded under the Plan.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. All eligible expenses Incurred at a Participating Provider will be reimbursed to the provider. Eligible expenses under the Plan are as follows:

- (1) **Accident Benefit:** Benefits are payable for eligible medical expenses Incurred as a result of an accidental Injury. Expenses must be Incurred within 90 days of the date of the Accident. Eligible expenses include charges Incurred upon the recommendation and approval of a duly qualified Physician and:
 - (a) Medical or surgical treatment rendered or prescribed by a Physician;
 - (b) Hospital room and board, services, and supplies; and
 - (c) X-ray or laboratory examinations.

Any expenses Incurred in excess of the maximum amount shall be payable according to the service rendered under the benefits otherwise provided by the Plan. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (2) **Acupuncture:** Services by a licensed Doctor of Medicine, Doctor of Osteopathic Medicine or Acupuncturist. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (3) **Allergy Services:** Allergy testing, serum and injections. Eligible expenses for allergy serum and injections will be payable as shown in the Medical Schedule of Benefits.
- (4) **Ambulance Service:** Professional ground or air ambulance service to transport the Covered Person to the nearest Hospital equipped to treat the specific Illness or Injury in an emergency situation; or
 - (a) To another Hospital in the area when the first Hospital did not have services required and/or facilities to treat the Covered Person; or
 - (b) To and from a Hospital during a period of Hospital confinement to another facility for special services which are not available at the first Hospital; or
 - (c) From the Hospital to the individual's home, or to a convalescent facility when there is documentation the Covered Person required ambulance transportation.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (5) **Ambulatory Surgery Center:** Services and supplies provided by an Ambulatory Surgery Center. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (6) **Anesthetics:** Anesthetics and their professional administration.
- (7) **Blood and Blood Derivatives:** Blood, blood plasma, or blood components not donated or replaced.

- (8) **Cardiac Rehabilitation:** Cardiac rehabilitation services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery, or any other medical condition if medically appropriate; and (c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and (d) in a medical care facility.

Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made, and exercise therapy that no longer requires the supervision of medical professionals.

- (9) **Chemotherapy:** Services and supplies related to chemotherapy.
- (10) **Chiropractic Care/Spinal Manipulation:** Skeletal adjustments, manipulation, or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (11) **Circumcision:** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as a newborn expense.
- (12) **Cosmetic Procedures/Reconstructive Surgery:** Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances:
- (a) For the correction of a Congenital Anomaly for a Dependent Child.
 - (b) Any other Medically Necessary Surgery related to an Illness or Injury.
 - (c) Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:
 - (i) Reconstruction of the breast on which the mastectomy has been performed;
 - (ii) Surgery and reconstruction of the other breast to produce symmetrical appearance; and
 - (iii) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Covered Person.

- (13) **Dental Care:** Dental services and x-rays rendered by Dentist or dental surgeon for:
- (a) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
 - (b) Emergency repair due to Injury to sound natural teeth within 6 months of an Accident, including the replacement of sound natural teeth.
 - (c) Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
 - (d) Excision of benign bony growths of the jaw and hard palate.
 - (e) External incision and drainage of cellulitis.
 - (f) Incision of sensory sinuses, salivary glands or ducts.

General anesthesia and Hospital expenses are covered for eligible dental care services that would require the service be preformed in a Hospital to monitor the patient due to a serious underlying medical condition, such as heart condition, blood disorder, etc., or is necessary due to accidental Injury to sound natural teeth.

- (14) **Diabetic Education:** The following diabetic education and self-management programs: diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with diabetes.
- (15) **Diabetic Supplies:** All Physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes that are not covered under the Prescription Drug Card program.
- (16) **Diagnostic Testing, X-ray and Laboratory Services:** Diagnostic testing, x-ray, and laboratory services, including services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under Dental Care.

The use of the Lab Card program offered by Quest Diagnostics is strictly voluntary. If a Covered Person uses the services of the Lab Card Program, benefits will be payable as shown in the Medical Schedule of Benefits. When a Physician orders laboratory work, the Covered Person should present the Lab Card or Employee identification card with the Lab Card logo on it and verbally request to use the Lab Card Program. The Physician will then collect the specimen and send to Quest Diagnostics. Any Physician can collect specimens and call Quest Diagnostics Lab Card Client Services at (800) 646-7788 for courier pick-up and supplies. In the event the Physician does not participate with the Lab Card Program, simply take the test orders to an approved Lab Card collection site for the draw. Collection site locations can be found by calling Lab Card Client Services or by going to the website at www.labcard.com.

The Lab Card Program covers routine outpatient testing. The Lab Card does NOT cover: (a) testing ordered during hospitalization; (b) lab work needed on an emergency or STAT basis; (c) testing done at another laboratory; or (d) time sensitive esoteric testing such as fertility testing, bone marrow studies and spinal fluid tests.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (17) **Durable Medical Equipment:** Initial purchase, repair and replacement, or (at the option of the Plan) rental of equipment that can stand repeated use, is appropriate for home use and manufactured mainly to treat sick or injured persons.

Charges for Durable Medical Equipment will be covered when Medically Necessary with the following exception: purchase or rental (at the Plan's option) of lab testing equipment, when prescribed by a Physician for a Medically Necessary test, would be covered provided the allowable charge for the test within one (1) year is projected to equal or exceed the allowable cost of the Durable Medical Equipment.

Covered charges do not include and the Plan will pay no benefits for:

- (a) Routine maintenance.
- (b) Repair of rental equipment.
- (c) Charges for deluxe items to the extent they exceed the cost of standard items.

Benefits for Durable Medical Equipment will not exceed the purchase price of the equipment.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(18) **Emergency Services:** The Plan will pay the greater of the following amounts for Emergency Services received from Non-Participating Providers:

- (a) The amount negotiated with Participating Providers for Emergency Services provided, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider. If there is more than one amount negotiated with Participating Providers for the Emergency Services provided, the amount paid shall be the median of the negotiated amounts, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider; or
- (b) The amount for the Emergency Services calculated using the same method the Plan generally uses to determine payments for services provided by a Non-Participating Provider (such as Usual and Customary Charge), excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider; or
- (c) The amount that would be paid under Medicare (Part A or Part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Services, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(19) **Foot Care:** Treatment for the following foot conditions: (a) bunions, when an open cutting operation is performed; (b) non-routine treatment of corns or calluses; (c) toenails when at least part of the nail root is removed; (d) any Medically Necessary Surgical Procedure required for a foot condition. In addition, orthopedic shoes when an integral part of a leg brace will also be covered.

(20) **Genetic Testing:** Diagnostic testing of Genetic Information and counseling when Medically Necessary. Genetic testing is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(21) **Hemodialysis/Peritoneal Dialysis:** Treatment of a kidney disorder by hemodialysis or peritoneal dialysis as an Inpatient in a Hospital or other facility, or for expenses in an outpatient facility or in the Covered Person's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person's home as shown under the Durable Medical Equipment benefit.

(22) **Home Health Care:** Services provided by a Home Health Care Agency to a Covered Person in the home. The following are considered eligible home health care services:

- (a) Home nursing care;
- (b) Services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.);
- (c) Visits provided by a medical social worker (MSW);
- (d) Physical, occupational or speech therapy if provided by the Home Health Care Agency;
- (e) Medical supplies, drugs and medications prescribed by a Physician;
- (f) Laboratory services; and
- (g) Nutritional counseling by a licensed dietician.

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each four (4) hours of home health aide services shall be considered as one home health care visit.

In no event will the services of a Close Relative, transportation services, housekeeping services, and meals, etc., be considered an eligible expense.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (23) **Hospice Care:** Hospice care on either an inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of six months or less.

Covered services include:

- (a) Room and board charges by the Hospice.
- (b) Other Medically Necessary services and supplies.
- (c) Nursing care by or under the supervision of a registered nurse (R.N.).
- (d) Home health care services furnished in the patient's home by a Home Health Care Agency for the following:
 - (i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and
 - (ii) physical and speech therapy.
- (e) Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family.
- (f) Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family within six months after the patient's death. For the purposes of bereavement counseling, the term "Patient's Immediate Family" means the patient's spouse, parents of a Dependent Child, and/or Dependent children who are covered under the Plan.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits

- (24) **Hospital Services or Long-Term Acute Care Facility/Hospital:**

- (a) Inpatient

Room and board, including all regular daily services in a Hospital or Long-Term Acute Care Facility/Hospital will be payable as shown in the Medical Schedule of Benefits. Care provided in an Intensive Care Unit (including cardiac care (CCU) and burn units) will be payable as shown in the Medical Schedule of Benefits.

Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis.

- (b) Outpatient

Services and supplies furnished while being treated on an outpatient basis will be payable as shown in the Medical Schedule of Benefits.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(25) **Lenses:** Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye or for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages.

(26) **Maternity:** Expenses Incurred by all Covered Persons for:

- (a) Pregnancy.
- (b) Preventive prenatal and breastfeeding support as identified under the preventive services section below.
- (c) Services provided by a Birthing Center.
- (d) Amniocentesis testing and ultrasounds.

Elective induced abortions in the case of fetal abnormality or when carrying the fetus to full term would seriously endanger the life of the mother will be a Covered Expense for any Covered Person. If complications arise after the performance of any abortion for any Covered Person, any expenses Incurred to treat those complications will be eligible, whether the abortion was eligible or not.

Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission, unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified or a penalty may be applied.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(27) **Medical and Surgical Supplies:** Casts, splints, trusses, braces, crutches, orthotics (excluding foot orthotics), dressings, and other Medically Necessary supplies ordered by a Physician.

(28) **Mental Disorders:** Care, supplies and treatment of a Mental Disorder. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(29) **Morbid Obesity:** Surgical and non-surgical care and treatment of Morbid Obesity.

(30) **Nutritional Supplements:** Physician-prescribed nutritional supplements or other enteral supplementation necessary to sustain life, including rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation. Special dietary treatment for phenylketonuria (PKU) when prescribed by a Physician.

Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(31) **Occupational Therapy:** Rehabilitative occupational therapy rendered by a qualified Physician or a licensed occupational therapist under the recommendation of a Physician. Expenses for Maintenance Therapy or therapy primarily for recreational or social interaction will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(32) **Off-Label Drug Use:** Off-Label Drug Use will be covered when all of the following additional criteria have been satisfied:

- (a) The drug is not excluded under the Plan; and

- (b) The drug has been approved by the FDA; and
 - (c) It can be demonstrated to the Plan's satisfaction that the Off-Label Drug Use is appropriate and generally accepted for the condition being treated; and
 - (d) If the drug is used for the treatment of cancer, the American Hospital Formulary Service Drug Information, or the NCCN Drugs and Biologics Compendia, recognize it as an appropriate treatment for that form of cancer.
- (33) **Outpatient Pre-Admission Testing:** Outpatient pre-admission testing performed within 7 days of a scheduled Inpatient hospitalization or Surgery. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (34) **Physical Therapy:** Physical therapy rendered by a qualified Physician or a licensed physical therapist under the recommendation of a Physician. Maintenance Therapy will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (35) **Physician's Services:** Services of a Physician for medical care or Surgery.
- (a) Services performed in a Physician's office on the same day for the same or related diagnosis, regardless if a Physician is seen or not, will be payable as shown in the Medical Schedule of Benefits. Services include, but are not limited to: examinations, x-ray and laboratory tests (including the reading or processing of the tests), supplies, injections, cast application, and minor Surgery. If more than one Physician is seen in the same clinic on the same day, only one Copay will apply.
 - (b) Diagnostic x-ray and laboratory services which are ordered on the same day as the office visit, but performed or read at a later date and/or at another facility will be considered as part of the office visit.
 - (c) For multiple or bilateral surgeries performed during the same operative session which are not incidental, or not part of some other procedure, and which add significant time or complexity (all as determined by the Plan) to the complete procedure, the charge considered will be: (a) 100% for the primary procedure; (b) 50% for the secondary procedure, including any bilateral procedure; and (c) 50% for each additional covered procedure. This applies to all Surgical Procedures, except as determined by the Plan.

For surgical assistance by an Assistant Surgeon, the charge will be 20% of the Usual and Customary Charge for the corresponding Surgery.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (36) **Preventive Services:** The following preventive services are paid as shown in the Medical Schedule of Benefits:

Preventive Services Under Health Care Reform

Evidence-based preventive services

Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (the "Task Force") with respect to the individual involved, except that with respect to breast cancer screening, mammography, and prevention of breast cancer, the recommendations of the Task Force issued in 2002 will be considered the current recommendations until further guidance is issued by the Task Force or the Health Resources and Services Administration.

Routine Vaccines

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

Prevention for Children

With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Prevention for Women

With respect to women, such additional preventive care and screenings, not otherwise addressed by the Task Force, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and published on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services). Those guidelines generally include the following:

- (A) **Well-Woman Visits.** Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The inclusion of a well-woman visit is not meant to limit the coverage for any other preventive service described elsewhere in this Plan document that might be administered as part of the well-woman visit.

Coverage for prenatal care is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman. In the event a provider bills a "maternity global rate", the portion of the claim that will be considered for prenatal visits and therefore, preventive care, is 40% of the "maternity global rate". As a result, 60% of the "maternity global rate" will be considered for delivery and postnatal care and the normal cost-sharing provisions would apply. Items not considered preventive (and therefore subject to normal cost-sharing provisions) include inpatient admissions, high risk specialist units, ultrasounds, amniocentesis, fetal stress tests, delivery including anesthesia and certain pregnancy diagnostic lab tests.

- (B) **Screening for gestational diabetes.** A maximum of three (3) screenings per plan year for gestational diabetes shall be covered in pregnant women.
- (C) **Human papillomavirus (HPV) testing.** High-risk HPV DNA testing in women with normal cytology results. Screening is limited to women age 30 or older and is limited to one (1) screening every three (3) Calendar Years.
- (D) **Counseling annually for sexually transmitted infections (including for the human-immune-deficiency virus (HIV)) and screening annually for HIV for all sexually active women.** Limited to two (2) counseling sessions per Calendar Year.
- (E) **Screening and counseling annually for interpersonal and domestic violence.**
- (F) **Contraceptive methods and counseling, as prescribed by your Physician.** All FDA approved contraceptive methods, sterilization procedures and patient education and counseling for women with reproductive capacity. Contraceptive counseling is limited to 2 visits per 12-month period. Abortifacient drugs are not included.

For purposes of the above, the sterilization procedures to be considered preventive include sterilization implant (Essure) and surgical sterilization (Sterilization) either abdominally, vaginally or laparoscopically. Eligible charges for a sterilization procedure and all ancillary services will be covered when sterilization is the primary purpose of the services provided and/or if it is performed as a standalone procedure and billed as such. However, complications arising following a sterilization procedure are not covered as preventive services. Covered Expenses do not include charges for a sterilization procedure to the extent the procedure was not billed separately by the provider or because it was not the primary purpose of the procedure. To the extent sterilization is

part of another procedure and/or is not a separate line on the bill, the sterilization procedure is not a Covered Expense.

(G) Breastfeeding support, supplies and counseling in conjunction with each birth, including the following:

- (1) Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postnatal period (60 days from baby's date of birth). Lactation consultation is limited to 6 cumulative visits per 12-month period.
- (2) Breastfeeding equipment will be covered, subject to the following:
 - (a) Rental of a Hospital grade electric pump while the baby is Hospital confined; and
 - (b) Purchase of a standard (non-Hospital grade) electric breast pump or manual breast pump if requested within 60 days (electric) or 12 months (manual) from the baby's date of birth, provided the Covered Person has not received either a standard electric breast pump or a manual breast pump within the last three (3) Calendar Years.

For women using a breast pump from a prior pregnancy, 1 new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding within the first 12 months from the baby's date of birth.

For a detailed listing of women's preventive services, please visit the U.S. Department of Health and Human Services website at: <http://www.hrsa.gov/womensguidelines>. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such preventive services to the extent required by such guidelines.

Preventive Drugs

Preventive Drugs that are not covered under the Prescription Drug Card Program. Please contact the Prescription Drug Card Program Administrator for a list of medications.

For a detailed listing of preventive services, please visit the U.S. Department of Health and Human Services website at:

<http://www.healthcare.gov/center/regulations/prevention/recommendations.html>. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any Preventive Drug required to be covered by the U.S. Department of Health and Human Services (HHS) the above shall be deemed to be amended to cover such Preventive Drug to the extent required by the HHS.

Other Preventive Services

Other preventive services including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or inoculations (including pre-travel and Visa related), well child care, pap smears, mammograms (includes computer assisted diagnosis mammography), colon exams, PSA testing, bone density, CA125, CBC, chest x-ray, complete metabolic panel, CRP, echocardiogram, ferritin, Gardasil, hematology, hepatic panel, iron/TIBC lipid profile, pulmonary function test, routine EKG/ECG, gynecological exams, sigmoidoscopies, sedimentation rate, SMAC-19, T3, TSH, uric acid, ultrasound for breast cancer screening, and vitamin B-12. If a diagnosis is indicated after a preventive exam, the exam will still be payable under the preventive services benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other illness.

The above routine care items are covered in addition to and to the extent they are not otherwise included for coverage under the Preventive Services section of the Plan.

- (37) **Private Duty Nursing:** Private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to the following extent:
- (a) Inpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit. Inpatient Private Duty Nursing must be supported by a certification from the attending Physician.
 - (b) Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and provided under the Home Health Care and Hospice Care benefits.
- (38) **Prosthetic Devices:** Artificial limbs, eyes, or other prosthetic devices when necessary due to an Illness or Injury. This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (39) **Radiation Therapy:** Radium and radioactive isotope therapy treatment.
- (40) **Reconstructive Surgery:** See Cosmetic Procedures/Reconstructive Surgery.
- (41) **Rehabilitation Facility:** Inpatient care provided in a Rehabilitation Facility will be payable as shown in the Medical Schedule of Benefits, provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Facility confinement; and (c) is not for Custodial Care.

See the Skilled Nursing Facility benefit for services and supplies provided for confinements in a Skilled Nursing Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (42) **Routine Newborn Care:** Routine newborn care including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the newborn's expense.

If the newborn is ill, suffers an Injury, or requires care other than routine care, benefits will be provided on the same basis as any other eligible expense.

- (43) **Second Surgical Opinion:** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person.

Benefits for the second opinion will be payable only if the opinion is given by a specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery.

If the second opinion conflicts with the first opinion, the Covered Person may obtain a third opinion, although this is not required. The Covered Person may choose to follow the first or second opinion, if voluntary.

- (44) **Skilled Nursing Facility:** Skilled nursing care provided in a Skilled Nursing Facility will be payable as shown in the Medical Schedule of Benefits, provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and (c) is not for Custodial Care.

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (45) **Sleep Disorders:** Sleep disorder treatment that is Medically Necessary.
- (46) **Speech Therapy:** Restorative or rehabilitative speech therapy rendered by a qualified Physician or a licensed speech therapist under the recommendation of a Physician, necessary because of loss or impairment due to an Illness, Injury or Surgery, or therapy to correct a Congenital Anomaly. Speech therapy for developmental delay or to change voice sound will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (47) **Sterilization:** Elective sterilization procedures (this does not include reversal of sterilization). Elective sterilization procedures are covered in addition to and to the extent they are not otherwise included for coverage under the preventive services section of the Plan.
- (48) **Substance Use Disorders:** Charges for care, supplies and treatment of a Substance Use Disorder. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (49) **Temporomandibular Joint Dysfunction (TMJ):** Surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ). The treatment of jaw joint disorders (TMJ) includes conditions of structures linking the jawbone and skull and complex muscles, nerves, and other tissues related to the temporomandibular joint. Treatment shall include, but is not limited to: orthodontics; physical therapy; and any appliance that is attached to or rests on the teeth.
- (50) **Transplants (other than those received at an Aetna IOE facility):** The transplant of organs from human to human, including bone marrow, stem cell and cord blood transplants. Transplants include only those transplants that: (a) are approved for Medicare coverage on the date the transplant is performed; and (b) are not otherwise excluded by this Plan.

See the Aetna Institute of Excellence section of the Plan with respect to transplant coverage performed at an Aetna IOE Facility.

A transplant must be Medically Necessary and performed at a Transplant Facility in order to be considered for reimbursement under this Plan. Skin and cornea transplants are not considered a Transplant for the purpose of determining eligible.

Transplants are subject to the following conditions:

- (a) If both the donor and the recipient are covered under this Plan, eligible expenses Incurred by each person will be treated separately for each person.
- (b) If the donor is covered under this Plan and the recipient is not covered, eligible expenses Incurred by the donor will be considered eligible.
- (c) The Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology and pathology fees for the removal of the organ and a Hospital's charge for storage or transportation of the organ.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Exclusions:

- (a) Non-human and artificial organ transplants, and any transplants not listed as eligible above;

- (b) The purchase price of any of bone marrow, organ, tissue or any similar items which are sold rather than donated; and
- (c) Transplants which are not medically recognized and are Experimental and/or Investigational in nature.

Sun Excel Transplant Program

In addition to the standard transplant benefit as stated above, the following additional covered benefits are available when a Covered Person participates in this special transplant program. This special transplant program is an enhancement to the standard transplant benefit and participation is voluntary.

Additional Covered Benefits

- (1) Access to Centers of Excellence Transplant Facilities throughout the United States.
- (2) Reimbursement, up to a total of \$5,000 for expenses incurred by the Covered Person (recipient) and one companion, or both parents or both legal guardians if the Covered Person (recipient) is a minor child:
 - (a) For travel to and from the Centers of Excellence facility when that travel is related to the actual transplant occurrence;
 - (b) For lodging expenses related to such travel and occurring prior to and following the actual transplant occurrence.
- (3) Waiver of the recipient's Deductible and Co-insurance up to \$1,500 during the year in which the transplant occurs (if applicable under the Plan).

Requirements

This special transplant benefit is only available when a Covered Person (recipient) participates in this transplant program and satisfies all of the following requirements:

- (1) Notification of the transplant procedure must be provided to Meritain Health Medical Management in accordance with its guidelines.
- (2) The Covered Person's representative or whomever the Employer or Contract Administrator designates must call the Special Transplant Program at 1-800-432-1102 extensions 1148, 2387, 1359 or 1135 as soon as the Covered Person (recipient) is identified as a potential transplant candidate to notify the Special Transplant Program of the impending transplant; and
- (3) All transplant services must be rendered at a Centers of Excellence Transplant Facility which participates in this program for the specific organ or tissue transplant required. A current list of participating Centers of Excellence facilities for each type of transplant is available from Meritain Health Medical Management.

For more information on the program please contact the Employer.

- (51) **Urgent Care Facility:** Services and supplies provided by an Urgent Care Facility. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

AETNA INSTITUTE OF EXCELLENCE (IOE)

The Institute of Excellence (IOE) is a facility that contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Transplant Expenses

Once it has been determined that you or one of your eligible Dependents may require an organ transplant, you or your Physician must call the Medical Management Program Administrator to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements. Organ means solid organ; stem cell; bone marrow and tissue.

Benefits may vary if an IOE facility or a non-IOE facility is used. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered at the Participating Provider level only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants that is provided by a facility that is not specified as an IOE network facility, even if the facility is considered a Participating Provider for other types of services, will be covered at the Non-Participating Provider level. Please read each section below carefully.

Covered Transplant Expenses

Covered transplant expenses include the following:

- (1) Charges for activating the donor search process with national registries.
- (2) Compatibility testing of prospective organ donors that are immediate family member. For purposes of this section an "immediate" family member is defined as a first-degree biological relative. These are your biological parent, sibling or child.
- (3) Inpatient and outpatient expenses directly related to a transplant.
- (4) Charges made by a Physician or a transplant team.
- (5) Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- (6) Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant services are typically Incurred during the four (4) phases of transplant care described below. Expenses Incurred for one transplant during these four (4) phases of care will be considered one (1) transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date the patient is discharged from the Hospital or outpatient facility for the admission or visits related to the transplant, whichever is later.

The four (4) phases of one (1) transplant occurrence and a summary of covered transplant expense during each phase are as follows:

- (1) Pre-transplant evaluation/screening. Pre-transplant evaluation screening includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.

- (2) Pre-transplant candidacy screening. Pre-transplant candidacy screening includes Human Leukocyte Antigen (HLA) typing/compatibility testing of prospective organ donors that are immediate family members.
- (3) Transplant event. A transplant event includes Inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your Inpatient stay or outpatient visits, including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your Inpatient stay or outpatient visits; cadaveric and live donor procurement.
- (4) Follow-up care. Follow-up care includes all covered transplant expenses; home health care services; home infusion services and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

One Transplant Occurrence

The following are considered one (1) transplant occurrence:

- (1) Heart.
- (2) Lung.
- (3) Heart/Lung (simultaneous).
- (4) Pancreas.
- (5) Kidney.
- (6) Liver.
- (7) Small bowel.
- (8) Bone marrow transplant or peripheral stem cell infusion when a positive response to standard medical treatment or chemotherapy has been documented. Coverage is for one transplant or infusion only within a 12 month period, unless a tandem transplant or infusion meets the Plan's definition of Medically Necessary and is not excluded from coverage as Experimental/Investigational.
- (9) Cornea.
- (10) Skin.

More Than One Transplant Occurrence

The following are considered more than (1) transplant occurrence:

- (1) Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant).
- (2) Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).
- (3) Re-transplant after 180 days of the first transplant, except as specified for bone marrow/stem cell.
- (4) Pancreas transplant following a kidney transplant.
- (5) A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- (6) More than one (1) transplant when not performed as part of a planned tandem or sequential transplant (i.e. a liver transplant with subsequent heart transplant).

Limitations

Transplant coverage does not include charges for the following:

- (1) Services and supplies furnished to a donor when recipient is not a Covered Person.
- (2) Home infusion therapy after the transplant occurrence.
- (3) Harvesting or storage of organs without the expectation of immediate transplant for an existing illness.
- (4) Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
- (5) Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

Travel and Lodging Expenses

Travel and lodging expenses will be covered under the Plan subject to the conditions described below.

- (1) Distance requirement. The IOE facility must be more than 100 miles away from the transplant recipient's residence.
- (2) Travel allowances. Travel is reimbursed between the transplant recipient's home and the facility for round trip (air, train or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll cost will be reimbursed. Mileage reimbursement is \$.14 per mile.
- (3) Lodging allowances. Reimbursement of expenses incurred by the transplant recipient and any companion for hotel lodging away from home is reimbursed at a rate of \$50 per night, per person to a maximum of \$100 per night.
- (4) Overall maximum. Travel and lodging reimbursement is limited to \$10,000 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the transplant recipient and companion.
- (5) Companions. One (1) companion is permitted per adult and two (2) parents or guardians are permitted per Child.

ALTERNATIVE BENEFITS

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternative treatment plan, if the charges Incurred for services provided to a Covered Person under such alternate treatment plan to its end, will be more cost effective than those charges to be Incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative treatment plan is Medically Necessary and cost effective. If the Plan elects to provide alternative treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person, or from future benefits, and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

- (1) **Abortions:** Expenses related to elective abortions will not be considered eligible. This exclusion does not apply to any expenses Incurred for an abortion in the case of fetal abnormality or when the life of the mother is endangered by a continued pregnancy or to treat any complications arising after the performance of an abortion.
- (2) **Adoption:** Expenses related to adoption will not be considered eligible.
- (3) **Attention Deficit Disorder:** Expenses to treat behavioral conditions related to Attention Deficit Hyperactivity Disorder (ADD or ADHD) will not be considered eligible, except as considered a preventive service under Eligible Medical Expenses.
- (4) **Autism:** Expenses to treat behavioral conditions related to autism will not be considered eligible, except as considered a preventive service under Eligible Medical Expenses.
- (5) **Barrier-Free Home Modifications:** Expenses for barrier-free home modifications whether or not recommended by a Physician, including, but not limited to, ramps, grab bars, railings, or standing frames will not be considered eligible.
- (6) **Biofeedback:** Expenses related to biofeedback will not be considered eligible.
- (7) **Breast Implants:** Expenses for insertion, removal or revision of breast implants will not be considered eligible, unless provided post-mastectomy.

Expenses for treatment or service for any illness or condition for which the insertion of breast implants or the fact of having breast implants within the body was a contributing factor, unless the illness or condition occurs post-mastectomy.
- (8) **Cardiac Rehabilitation:** Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made, and exercise therapy that no longer requires the supervision of medical professionals.
- (9) **Chelation Therapy:** Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning.
- (10) **Close Relative:** Expenses for services, care or supplies provided by a Close Relative will not be considered eligible.
- (11) **Cognitive and Kinetic Therapy:** Expenses for cognitive therapy and kinetic therapy will not be considered eligible. Cognitive therapy is defined as therapy which embraces mental activities associated with thinking, learning, and memory. Kinetic therapy is defined as therapy related to motion or movement (e.g., the study of motion, acceleration or rate of change). This exclusion will not apply to expenses related to a neurological brain impairment resulting from an acute major illness.
- (12) **Complications:** Expenses for care, services or treatment required as a result of complications from a treatment not covered under the Plan will not be considered eligible, except complications from abortions as specified under Eligible Medical Expenses.

- (13) **Communication-Assist Devices:** Expenses for non-implantable communicator-assist devices, including but not limited to, communication boards and computers will not be considered eligible.
- (14) **Contraceptives:** Expenses for contraceptive procedures and devices, including but not limited to, oral contraceptives, injections, and the placement or removal of a contraceptive device will not be considered eligible, except as specified under the Prescription Drug Card program or as Preventive Services under Eligible Medical Expenses.
- (15) **Convenience Items:** Expenses for personal hygiene and convenience items will not be considered eligible.
- (16) **Cosmetic Procedures:** Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under Eligible Medical Expenses.
- (17) **Counseling:** Expenses for religious, marital, or relationship counseling will not be considered eligible, except as specified under Eligible Medical Expenses.
- (18) **Custodial Care:** Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.
- (19) **Dental Care:** Expenses Incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible, except as specified under Eligible Medical Expenses. Removal of impacted teeth will not be considered eligible.
- (20) **Developmental Delays:** Expenses in connection with the treatment of developmental delays, including, but not limited to speech therapy, occupational therapy, physical therapy and any related diagnostic testing will not be considered eligible, except as considered a Preventive Service under Eligible Medical Expenses.
- (21) **Exercise Programs:** Exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.
- (22) **Experimental and/or Investigational:** Expenses for any Experimental or Investigational treatment, or for any Hospital confinement or treatment that results from Experimental or Investigational treatment will not be considered eligible.
- (23) **Foot Care:** Expenses for routine foot care, treatment of weak, unstable or flat feet will not be considered eligible, unless for the treatment of diabetes or as specified under Eligible Medical Expenses.
- (24) **Foot Orthotics:** Expenses for foot only orthotics, orthopedic shoes (except those that are an integral part of a leg brace), arch supports, or for the exam, prescription or fitting thereof will not be considered eligible.
- (25) **Gambling Addiction:** Expenses for services related to gambling addiction will not be considered eligible.
- (26) **Gene Therapy:** Expenses related to gene therapies, xenographs or cloning will not be considered eligible.
- (27) **Governmental Agency:** Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).
- (28) **Gynecomastia:** Expenses for gynecomastia (abnormal breast enlargement in males) will not be considered eligible.
- (29) **Hair Loss:** Expenses for hair loss or hair transplants will not be considered eligible.

- (30) **Hearing Exams/Aids:** Expenses for routine hearing examinations, hearing aids (including the fitting thereof) and supplies will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.
- (31) **Homeopathic Treatment:** Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.
- (32) **Hypnotherapy:** Expenses for hypnotherapy will not be considered eligible.
- (33) **Illegal Occupation/Felony:** Expenses for or in connection with an Injury or Illness arising out of an illegal occupation or commission of a felony will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.
- (34) **Infertility:** Expenses for confinement, treatment, testing or services related to infertility (the inability to conceive) or the promotion of conception will not be considered eligible.
- Nothing in this section is intended to exclude coverage for any infertility counseling or treatment required to be covered (if any) as a preventive service under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines).
- (35) **Maintenance Therapy:** Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.
- (36) **Mandible Treatment:** Expenses for appliances, medical or surgical treatment for correction of a malocclusion or protrusion or recession of the mandible; maxillary or mandibular hyperplasia, or maxillary or mandibular hypoplasia will not be considered eligible. (Malocclusion - teeth do not fit together properly, bite problem; mandible protrusion or recession: underbite, chin excessively large or overbite, chin abnormally small; maxillary/mandibular hyperplasia: overbite due to excess growth of upper/lower jaw; maxillary/mandibular hypoplasia: undergrowth of upper/lower jaw). This is considered dental Surgery, performed by dental surgeons. This is not considered a medical procedure.
- (37) **Massage Therapy:** Expenses for massage therapy will not be considered eligible.
- (38) **Medically Necessary:** Expenses which are determined not to be Medically Necessary will not be considered eligible.
- (39) **Missed Appointments:** Expenses for completion of claim forms, missed appointments or telephone consultations will not be considered eligible.
- (40) **No Legal Obligation:** Expenses for services provided for which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Employer's plan to be primary.
- (41) **Non-Covered Procedures:** Expenses for services related to a non-covered Surgery or procedure will not be considered eligible regardless of when the Surgery or procedure was performed. This exclusion does not apply to complications of an abortion or of a Dependent child's pregnancy.
- (42) **Not Performed Under the Direction of a Physician:** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.
- (43) **Not Recommended by a Physician:** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.
- (44) **Nutritional Counseling:** Expenses related to nutritional counseling will not be considered eligible, except if received as part of the Home Health Care benefit and except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

- (45) **Nutritional Supplements:** Expenses for nutritional supplements or other enteral supplementation will not be considered eligible, except as specified under Eligible Medical Expenses. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.
- (46) **Obesity:** Surgical and non-surgical care and treatment of obesity including weight loss or dietary control, whether or not it is in any case a part of a treatment plan for another illness, will not be considered eligible, except for Morbid Obesity or as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.
- (47) **Occupational Therapy:** Expenses for occupational therapy primarily for recreational or social interaction will not be considered eligible.
- (48) **Operated by the Government:** Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related illness or injury.
- (49) **Outside the United States (U.S.):** Expenses for services or supplies if the Covered Person leaves the U.S., or the U.S. Territories for the express purpose of receiving medical treatment will not be considered eligible.
- Expenses for a patient who becomes sick or injured while out of the U.S. or the U.S. Territories will not be considered eligible after 120 consecutive days. This time limit will not be applied if the Covered Person is out of the country for business or as a student.
- (50) **Over-the-Counter (OTC) Medication:** Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive services under the Eligible Medical Expenses section of the Plan.
- (51) **Physician Overhead:** Expenses for Physician overhead, including but not limited to equipment used to perform the particular treatment or service (i.e. laser equipment) will not be considered eligible.
- (52) **Plan Maximums:** Charges in excess of Plan maximums will not be considered eligible.
- (53) **Positional Head Deformity:** Expenses for non-synostotic plagiocephaly (positional head deformity) will not be considered eligible.
- (54) **Prior to Effective Date:** Expenses which are Incurred prior to the effective date of your coverage under the Plan will not be considered eligible.
- (55) **Radioactive Contamination:** Expenses Incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.
- (56) **Recreational and Educational Therapy:** Expenses for recreational and educational services; learning disabilities; behavior modification services; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies; will not be considered eligible. Diabetic education is considered eligible as specified under Eligible Medical Expenses..
- (57) **Refractive Errors:** Expenses for radial keratotomy, lasik Surgery or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible.
- (58) **Required by Law:** In any case where an individual is required by law to maintain insurance coverage (or to maintain any other security or reserve amount in lieu of insurance coverage), expenses of a Covered Person that would be paid by such insurance coverage are not eligible expenses, regardless of whether the individual is in fact covered under such coverage. For purposes of any required automobile, motorcycle or other vehicle coverage, otherwise eligible expenses below the minimum required coverage or the actual coverage elected, whichever is higher, will be excluded from coverage under this Plan.

- (59) **Riot/Revolt:** Expenses resulting from a Covered Person's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.
- (60) **Sex Transformation:** Expenses in connection with sex transformation will not be considered eligible.
- (61) **Sexual Dysfunction:** Expenses for services, supplies or drugs related to sexual dysfunction not related to organic disease will not be considered eligible. Expenses for sex therapy will not be considered eligible.
- (62) **Sleep Disorder:** Expenses for unattended home sleep studies will not be considered eligible.
- (63) **Smoking Cessation:** Expenses for smoking cessation programs, including smoking deterrents will not be considered eligible, unless otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.
- (64) **Stand-by Physician:** Expenses for technical medical assistance or stand-by Physician services will not be considered eligible.
- (65) **Sterilization:** Expenses for the reversal of elective sterilization will not be considered eligible.
- (66) **Stress Management:** Expenses related to stress management will not be considered eligible.
- (67) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan, including but not limited to pre-pregnancy, conception, pre-natal, childbirth and post-natal expenses, will not be considered eligible.
- (68) **Travel:** Expenses for travel will not be considered eligible, except ambulance services or as specified under the transplant benefit.
- (69) **Usual and Customary Charge:** Expenses in excess of the Usual and Customary Charge will not be considered eligible.
- (70) **Vision Care:** Expenses for vision care, including routine eye exams, professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices will not be considered eligible, except as considered a preventive service under Eligible Medical Expenses. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages.

Expenses for orthoptic and vision therapy will not be considered eligible.

- (71) **Vocational:** Expenses for treatment or service for work-hardening services or vocational rehabilitation programs will not be considered eligible.
- (72) **Wage or Profit:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for wage or profit (including self-employment) will not be considered eligible.
- (73) **War:** Expenses for the treatment of Illness or Injury resulting from a war or any act of war or terrorism, whether declared or undeclared, or while in the armed forces of any country or international organization will not be considered eligible.
- (74) **Weekend Admissions:** Expenses for care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or Saturday will not be considered eligible, unless Surgery is scheduled within 24 hours.

(75) **Worker's Compensation:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Worker's Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Worker's Compensation or similar law and have reached the maximum reimbursement paid under Worker's Compensation or similar law will not be eligible for payment under this Plan.

PREScription DRUG CARD PROGRAM

Eligible expenses include Prescription Drugs and medicines prescribed in writing by a Physician and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician, diabetic supplies and oral contraceptives and contraceptive patches (regardless of intended use). Please note Prescription Drugs are subject to the cost-sharing provisions described in the Prescription Drug Schedule of Benefits unless the Prescription Drug qualifies as a Preventive Drug (as described below).

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 30-day supply.

When using the mail order program, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Expenses for injectables that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under this Plan subject to any applicable major medical Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to the major medical component of the Plan. Please refer to the Eligible Medical Expenses and the General Limitations and Exclusions section of the Plan.

Note: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Plan Sponsor and will not be subject to any limitations and exclusions under the major medical component of the Plan (except for injectables that are not covered under the Prescription Drug Card Program). However, Prescription Drugs are subject to the overall Calendar Year maximum shown in the Medical Schedule of Benefits. For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Prescription Drug Card Program Manager identified in the General Information section of this Plan and listed on the back of your Employee identification card.

Dispense as Written

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Brand Name drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Brand Name Drug in addition to the Brand Name Drug Copay. The Covered Person's share of the Prescription Drug cost does not apply toward the Plan's Out-of-Pocket Maximum.

Brand Name Drug: Means a trade name medication.

Generic Drug: A Prescription Drug, which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Prescription Drug: Any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, "Caution: federal law prohibits dispensing without prescription"; (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Preventive Drug: A list of Prescription Drugs, FDA approved contraceptive devices and FDA approved over-the-counter medications (including over-the-counter emergency contraceptives), when prescribed by a Physician, that have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. The term "Preventive Drug" does not include abortifacient drugs or over-the-counter contraceptives (other than FDA approved over-the-counter emergency contraceptives) regardless of whether or not such items are prescribed by a

Physician. Please contact the Prescription Drug Card Program Administrator for a complete listing of the Preventive Drugs covered under this Plan and any restrictions on the available drugs. You may also view the guidelines established by HHS by visiting the website at:

<http://www.healthcare.gov/center/regulations/prevention/recommendations.html>

and/or the website at:

www.healthcare.gov/law/resources/regulations/womensprevention.html

For a paper copy, please contact the Plan Administrator.

Note: Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age.

Please contact the Prescription Drug Card Program Administrator for a complete listing of the Preventive Drugs covered under this Plan and any applicable restrictions. To the extent the above does not cover any Preventive Drug or contraceptive device required to be covered by the U.S. Department of Health Human Services (HHS) or under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such Preventive Drug or contraceptive device to the extent required by the HHS and/or such guidelines.

DENTAL EXPENSES

If a Covered Person incurs expenses for a service on the list of "Eligible Dental Expenses," such charges are covered to the extent that they meet all of the following conditions:

- (1) Constitute Dentally Necessary treatment.
- (2) Are Incurred while covered under this Plan.
- (3) Are Usual and Customary Charges for Non-Participating Providers.

The Plan will pay for such eligible expenses as shown in the Schedule of Dental Benefits.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted.

Dental Participating Provider Organization

The Plan includes an arrangement with a Dental Participating Provider Organization (PPO). The Dental PPO name, address and phone number will be printed on the Employee identification card. The Dental PPO will apply to all Family members regardless of where the individual Family members may reside. The Plan Administrator will provide each Employee with information regarding his or her Dental PPO.

Date Expenses are Incurred

An expense is Incurred when the service is performed, except that it is deemed to be Incurred:

- (1) When the impression is taken in the case of dentures, or fixed bridgework;
- (2) When preparation of the tooth is begun in the case of crown work;
- (3) When the pulp chamber is opened in the case of root canal therapy.

Pre-Determination of Benefits

When the total cost of eligible dental expenses is expected to exceed the Pre-Determination Limit as shown in the Schedule of Dental Benefits, the Dentist's treatment plan should be sent to the Third Party Administrator before the first date of treatment. Based on the treatment plan, the Third Party Administrator will estimate the amount of the benefit available if treatment is performed and inform the Dentist of the determination. The treatment plan should:

- (1) Show the Dentist's proposed course of treatment;
- (2) Show the total charge for the treatment;
- (3) Include x-rays, study models and any other data requested by the Third Party Administrator;
- (4) Show how long the treatment will take; and
- (5) Show the classification of malocclusion (if the treatment plan is for Orthodontic Treatment).

Pre-determination is not necessary when eligible dental expenses are Incurred for emergency dental care or accidental dental injuries.

Pre-treatment review is not a guarantee of the benefits that will be payable. It tells the Covered Person and the Dentist, in advance, what is payable for the eligible dental services named in the treatment plan. But payment is conditioned on:

- (1) The work being done as proposed and while the Covered Person is covered under this Plan; and

- (2) The Deductible and payment limit provisions listed in the Dental Schedule of Benefits and all of the other terms of this Plan.

Alternative Treatment

The Plan has an "alternate treatment" clause that limits the Plan's payment to the most cost effective treatment of a dental condition that provides a professionally acceptable result as determined by national standards of dental practice. If a Covered Person chooses a more expensive treatment according to accepted standards of dental practice to correct a dental condition, the Plan's payment will be based on the treatment that provides professionally satisfactory results at the most cost-effective level.

Eligible Dental Expenses

Class A-Preventive Services:

Examinations

- (3) Oral examination (evaluation).
- (4) Periodic examination (evaluation).

Only one of the listed examinations will be covered twice each Calendar Year.

Radiographs

- (1) Full mouth survey:
 - (a) Complete series (including bitewings)
 - (b) Panoramic
- (2) Bitewings: For dependent children under age 18, limited to a maximum of four (4) bitewing films in one visit, once in any six (6) month period; for adults 18 years of age or older, limited to a maximum of four (4) bitewing films in one visit, once in any 12 consecutive month period.
- (3) Occlusal.
- (4) Periapical.
- (5) Extraoral x-rays:
 - (a) Sialography
 - (b) TMJ
 - (c) Cephalometric film
 - (d) Posterior-anterior or lateral skull and facial bone survey
 - (e) Other extraoral

Only one of the listed extraoral procedures will be covered in any six (6) consecutive months.

Diagnostic x-rays performed in conjunction with root canal therapy will not be considered Class A Services.

Preventive Services

- (1) Prophylaxis (cleaning of teeth) - covered twice each Calendar Year.
- (2) Topical application of fluoride - applicable only to Dependent children under age 16. Only one application will be covered in any six (6) consecutive months.
- (3) Space maintainers - applicable only to Dependent children under age 16. Repairs to space maintainers are not covered.
- (4) Topical application of sealants - applicable only to first and second permanent molars for Dependent children under age 16. Covered once each tooth in any 24 consecutive months.

Other Services

Harmful Habit Appliance or night guards - limited to one (1) time per person under the age of 16.

Class B-Basic Services:**Restorations**

- (1) Fillings (amalgam, silicate, plastic, or composite).

Multiple restorations on one (1) surface will be paid as a single filling. Replacement of existing fillings are covered only if at least 24 consecutive months have passed since placement of prior filling, unless required by new decay in an additional tooth surface. Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations.

- (2) Stainless steel crown.

Oral Surgery

- (1) Extraction of teeth
- (2) Alveoloplasty
- (3) Removal of dental cysts and tumors
- (4) Surgical incision and drainage of dental abscess
- (5) Surgical exposure to aid eruption
- (6) Excision of hyperplastic tissue

Periodontic Services

- (1) Scaling and root planing (each quadrant) – covered once each quadrant in any 24 consecutive months.
- (2) Periodontal appliance - one appliance is covered in any 36 consecutive months.
- (3) Periodontal prophylaxis (including probing, charting, exam, polishing, scaling, root planing and similar maintenance procedures). Covered if at least three (3) months have elapsed after completion of active therapeutic scaling and root planing or active surgical periodontal treatment and then not more than once in three (3) consecutive months.

Periodontal Surgical Procedures

- (1) Gingival flap procedure.
- (2) Gingivectomy.
- (3) Gingival curettage.

- (4) Osseous surgery.
- (5) Pedicle soft tissue graft.
- (6) Free soft tissue graft.

Only one (1) of the listed periodontal Surgical Procedures is covered for each quadrant in any 24 consecutive months.

Endodontic Services

- (1) Vital pulpotomy - covered for deciduous teeth only.
- (2) Root canal therapy including treatment plan, diagnostic x-rays, clinical procedures, and follow-up care:
 - (a) Apexification
 - (b) Apicoectomy
 - (c) Retrograde filling
 - (d) Root resection
 - (e) Hemisection

Anesthesia

- (1) General anesthesia
- (2) IV Sedation

General anesthesia or IV Sedation is covered as a separate procedure only when required for complex oral surgical procedures covered under this plan (and only when performed in a dental office).

Other Services

- (1) Emergency exam - covered as a separate procedure only if no other service (except x-rays) is provided during the visit.
- (2) Consultation with specialist - covered once in any 12 consecutive months.
- (3) Antibiotic drug injection.
- (4) Biopsy of oral tissue.
- (5) Palliative treatment - covered as a separate procedure only if no other service (except x-rays) is provided during the visit.
- (6) Recementing:
 - (a) Inlay
 - (b) Onlay
 - (c) Crown
 - (d) Bridgework

Covered only if done more than 12 months after initial insertion of inlay, onlay, crown, or bridge, and then not more than one time in any 24 consecutive months.

- (7) Repairs to complete or partial denture, bridge, or crown. Covered only if repair is done more than 12 months after initial insertion of denture, bridge, or crown, and then not more than one time in any 24 consecutive months.
- (8) Relining or rebasing complete or partial dentures. Covered only if relining or rebasing is done more than 12 months after initial insertion of the denture and then not more than one time in 24 consecutive months.
- (9) Tissue conditioning. Covered only if at least 12 months have elapsed since the insertion of a complete or partial denture and not more than once in any 24 consecutive months.
- (10) Denture adjustment. Covered once in any 12 consecutive months and only if at least 12 months have elapsed since the insertion of the denture.

Class C-Major Services:

Restorations

- (1) Inlays and onlays. Inlay or onlay restorations are covered only if the tooth cannot be restored by a filling and (for replacements) at least five (5) years (60 consecutive months) have elapsed since the last placement.
- (2) Labial veneer. Veneer restorations are covered only if the tooth cannot be restored by a filling and (for replacements) at least five (5) years (60 consecutive months) have elapsed since the last placement.
- (3) Crowns (single restorations only):
 - (a) Resin (laboratory)
 - (b) Resin, prefabricated
 - (c) Resin with nonprecious metal
 - (d) Resin with semiprecious metal
 - (e) Resin with gold
 - (f) Porcelain
 - (g) Porcelain with nonprecious metal
 - (h) Porcelain with semiprecious metal
 - (i) Porcelain with gold
 - (j) Gold (3/4 cast)
 - (k) Gold (full cast)
 - (l) Nonprecious metal (full cast)
 - (m) Semiprecious metal (full cast)

Crowns are covered only if the tooth cannot be restored by a filling and (for replacements) at least five years (60 consecutive months) have elapsed since the last placement. Crowns for the primary purpose of splinting, altering, or maintaining vertical dimension, or restoring occlusion are not covered. Crowns for the replacement of veneer, inlay or onlay are covered only if at least five (5) years (60 consecutive months) have elapsed since the last placement of the restoration. Crowning of implant replacing a tooth missing prior to the effective date is not covered. For persons under 16 years of age, the benefit for crown on vital teeth are limited to resin or stainless steel crowns.

- (4) Cast post and core. Covered only for teeth that have had root canal therapy.
- (5) Steel post and composite or amalgam. Covered only for teeth that have had root canal therapy.

Prosthodontics, Fixed

Fixed bridges - initial placement or replacement.

Initial placement of fixed bridges to replace teeth which were missing prior to the effective date of the individual's coverage will not be covered unless it includes the replacement of a functioning natural tooth extracted while the person is covered under the Plan (provided that the tooth was not an abutment to an existing partial denture that is less than five (5) years old). In that event, benefits are payable only for the replacement of those teeth which were extracted while covered under the Plan.

Benefits for the replacement of an existing fixed bridge are payable only if teeth are extracted while the person is covered under this plan or the existing bridge is more than five (5) years old, (60 consecutive months) and is not serviceable and cannot be repaired.

Prosthodontics, Removable

Complete or partial dentures - initial placement or replacement.

Initial placement of complete or partial dentures to replace teeth which were missing prior to the effective date of the individual's coverage will not be covered unless it includes the replacement of a functioning natural tooth extracted while covered under the Plan. In that event, benefits are payable only for the replacement of those teeth which were extracted while covered under the Plan.

Benefits for the replacement of an existing complete or partial denture are payable only if the existing denture is more than five (5) years old (60 consecutive months) and is not serviceable and cannot be repaired.

Covered charges for complete or partial dentures do not include any additional charges for over-dentures or for precision or semi-precision attachments.

Dental Implants

Class D-Orthodontia:

Formal, full-banded retention and treatment, including x-rays and other diagnostic procedure.

Removable or fixed appliances for tooth or bony structure guidance and retention.

DENTAL EXCLUSIONS AND LIMITATIONS

In addition to the General Exclusions and Limitations section of this Plan, no payment will be eligible under any portion of this Plan for Dental Expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person, or from future benefits, and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

- (1) **Alternative Treatment:** If a Covered Person chooses a more expensive treatment according to accepted standards of dental practice to correct a dental condition, the Plan's payment will be based on the treatment which provides professionally satisfactory results at the most cost-effective level.
- (2) **American Dental Association:** Expenses that do not meet the standards of dental practices accepted by the American Dental Association will not be considered eligible.
- (3) **Athletic mouth guards:** Expenses for athletic mouth guards will not be considered eligible.
- (4) **Attrition.** Expenses for treatment or service replacing tooth structure lost from abrasion or attrition will not be considered eligible.
- (5) **Bite Registration.** Expenses for bite registration or occlusal analysis will not be considered eligible.
- (6) **Cosmetic:** Expenses for services or supplies partially or wholly Cosmetic in nature will not be considered eligible.
- (7) **Correct Dental Condition.** Expenses for treatment or services which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three (3) years will not be considered eligible.
- (8) **Department Maintained by an Employer:** Expenses for services received from a Dentist or dental department maintained by an employer, labor union, etc., where the individual is eligible under any group insurance plan will not be considered eligible.
- (9) **Drugs:** Expenses for drugs and medicines (other than antibiotic injections) will not be considered eligible.
- (10) **Duplicate Devices:** Expenses for duplicate prosthetic devices or appliances; expenses for a lost or stolen dental appliance; will not be considered eligible.
- (11) **Harmful Habit Appliances:** Expenses for Harmful Habit appliances will not be considered eligible, except as specified in Eligible Dental Expenses.
- (12) **Hospital Expenses:** Expenses for Hospital expenses will not be considered eligible.
- (13) **Installation or Replacement:** Expenses for installation, replacement or alteration of, or addition to, dentures and fixed bridgework will not be considered eligible, except as shown in Eligible Dental Expenses.
- (14) **Medical Plan:** Expenses covered under the medical portion of the Plan will not be considered eligible.
- (15) **Not Performed By a Dentist:** Expenses for treatment by other than a Dentist or Physician will not be considered eligible, except charges for treatment performed under the supervision and direction of a Dentist or Physician by any person duly licensed or certified to perform such treatment under applicable professional statutes and regulations.
- (16) **Not Prescribed by a Dentist:** Expenses for services not prescribed as necessary by a Physician or Dentist will not be considered eligible.

- (17) **Occlusion:** Restorations or procedures to splint, change vertical dimension, or restore occlusion will not be considered eligible, except as shown in Eligible Dental Expenses.
- (18) **Oral Hygiene:** Expenses for oral hygiene, dietary or plaque control programs, or other educational programs will not be considered eligible.
- (19) **Orthognathic Surgery:** Surgery to correct malposition in the bones of the jaw will not be considered eligible.
- (20) **Personalization:** Expenses for personalization of dentures will not be considered eligible.
- (21) **Plan Design:** Expenses excluded or limited by the Plan design as stated in this document will not be considered eligible.
- (22) **Replacement:** Replacement of lost or stolen appliances will not be considered eligible.
- (23) **Take Home Items:** Expenses for take home items will not be considered eligible.
- (24) **Temporary:** Temporary dental service will be considered an integral part of the final dental service rather than a separate service.
- (25) **Temporary Prosthesis:** Expenses for a temporary full prosthesis or for adjustment or relining of a prosthesis within six months after the prosthesis is initially furnished will not be considered eligible.
- (26) **Temporomandibular Joint Dysfunction (TMJ):** Expenses Incurred for appliances or restorations in connection with Temporomandibular Joint Dysfunction (TMJ) or myofunctional therapy will not be considered eligible, except as specified under Eligible Dental Expenses
- (27) **Veneers:** Cosmetic veneers will not be considered eligible.

Extension of Benefits

If dental coverage under the Plan ceases and if you or your Dependents qualify, the plan will pay for:

- (1) Root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while you or a Dependent was covered under the Plan; and
- (2) Crowns, bridges, inlays or onlay restorations, but only if the tooth or teeth were fully prepared while you or a dependent was covered under the Plan; and
- (3) Complete or partial dentures, but only if the master impression was made while you or a Dependent was covered under the Plan; and
- (4) Orthodontia, but only if the appliance or bands were first set while the Dependent was covered under the Plan. The amount payable will be the part of the quarterly payment that would have been payable had coverage remained in force during the period extended benefits are payable;

provided the treatment or service is received within one (1) month after you or a Dependent's coverage terminates.

You or a Dependent will qualify if:

- (1) You or a Dependent would have qualified for benefit payment under the Plan had coverage remained in force; and
- (2) The treatment or service began while you or a Dependent was covered under the Plan; and
- (3) This Plan is in force at the time treatment of service is received.

However, no extended benefits will be paid for treatment or service received on or after the date you or your Dependents become eligible for other group dental expense coverage.

COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "qualifying event".

Qualified Beneficiary

In general, you, your Spouse and any Dependent Child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan is considered a "qualified beneficiary".

In addition, any Dependent Child who is born to or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary".

A Domestic Partner of an Employee and his or her children do not have any rights to continue Plan coverage under COBRA.

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualifying Event

If you are a covered Employee, you, your Spouse and/or Dependent Child will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced, or
- (2) Your employment ends for any reason other than your gross misconduct.

You, your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 18 months; provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage.

You, your Spouse and Dependent Child have an independent right to elect COBRA Continuation Coverage. You and/or your Spouse may elect coverage on behalf of either one of you and parents may elect coverage on behalf of their Dependent Child.

If you are the Spouse and/or Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events:

- (1) Your spouse/parent-Employee dies;
- (2) Your spouse/parent-Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- (3) You/your parents become divorced or legally separated.

Your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 36 months; provided such Spouse and/or Dependent Child provide notice of the qualifying event to the Human Resources Department and elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA Continuation Coverage and their obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If you are a Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose coverage under the Plan because you cease to be eligible for coverage under the Plan as a Dependent Child. You may elect to continue coverage under the Plan for up to a maximum period of 36 months; provided such Dependent Child provides notice of the qualifying event to the Human Resources Department and elects to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage and your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Extension of 18- month COBRA Continuation Period

If you, your Spouse or Dependent Child is determined to be disabled by the Social Security Act (SSA); you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to the Human Resources Department on a date that is both within 60 days after the later of (a) the date of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice and before the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify the Human Resources Department within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and any Dependent Child in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify for this extension in coverage, notification must be given to the Human Resources Department within 60 days after the later of (a) the date coverage under the Plan would end due to the qualifying event or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Notice Requirement

The notice must be in writing and postmarked by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost, and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are eligible for an extension of COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and Spouse or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

- (1) Name and address of the covered Employee or former employee;
- (2) Name and address of your Spouse, former Spouse and any Dependent Children;
- (3) Description of the qualifying event; and
- (4) Date of the qualifying event.

In addition to the information above, if you, your Spouse or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

- (1) Name of person deemed disabled;
- (2) Date of disability determination; and
- (3) Copy of SSA determination letter.

If you cannot provide a copy of the decree of divorce or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage, or extension of such coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

Notice must be sent to the COBRA Administrator at:

Meritain Health, Inc.
P.O. Box 860093
Minneapolis, MN 55486-0093
Fax No.: (763) 852-5079

Termination of COBRA Continuation Coverage

COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however coverage may end before the end of the maximum period on the earliest of the following events:

- (1) The date the Plan Sponsor ceases to provide any group health plan coverage;
- (2) The date on which the qualified beneficiary fails to pay the required contribution;
- (3) The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first). However, a qualified beneficiary who becomes covered under a group health plan which has a Pre-Existing Condition limit that affects that individual; he/she will be allowed to continue COBRA continuation coverage for the length of the pre-existing condition or to the COBRA maximum time period, if less; or
- (4) The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage

Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. The amount you are required to pay for COBRA continuation coverage is 102% of the actual cost of coverage you elect, unless you qualify for the 11-month period of extended coverage due to disability (as specified above). In the event of disability, you will be required to pay 150% of the actual cost of coverage you elect for the 11-month extension period.

Additional Information

Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator, who is identified on the General Information page of this Plan.

Current Addresses

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

CLAIM PROCEDURES

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information. The Employee identification card will show your Participating Provider Network, and the Medical Management Administrator.

At the time you receive treatment, show the Employee identification card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to the Claims Fiduciary at the following address:

Meritain Health, Inc.
P.O. Box 27267
Minneapolis, MN 55427-0267
1-800-925-2272

Most claims under the Plan will be “post service claims.” A “post service claim” is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

- (1) The date of service;
- (2) The name, address, telephone number and tax identification number of the provider of the services or supplies;
- (3) The place where the services were rendered;
- (4) The diagnosis and procedure codes;
- (5) The amount of charges (including Network repricing information);
- (6) The name of the Plan;
- (7) The name of the covered Employee; and
- (8) The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a “claim” since an actual written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Timely Filing

All claims must be filed with the Claims Fiduciary within 12 months following the date services were Incurred. Claims filed after this time period will be denied.

Procedures for all Claims

The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations, and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant (i.e. you and your covered Dependents) must follow the procedures outlined in this section. There are four (4) different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:

- (1) **Urgent Care Claims.** If your claim is considered an urgent care claim, the Claims Fiduciary will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. If you fail to provide sufficient information for the Plan to decide your claim, the Claims Fiduciary will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Fiduciary will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. In determining if the initial claim for benefits should be treated as an urgent care claim, the Plan will defer to a determination, if any, by an attending provider that the claim should be treated as an urgent care claim, if that determination is timely provided to the Plan.

- (2) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Claims Fiduciary will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Claims Fiduciary will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- (3) **Pre-Service Claims.** For a pre-service claim, the Claims Fiduciary will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Claims Fiduciary needs additional time to process a claim, the Claims Fiduciary may extend the time to notify you of the Plan's benefit determination for up to 15 days, provided that the Claims Fiduciary notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Claims Fiduciary expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

- (4) **Post-Service Claims.** For a post-service claim, the Plan Administrator will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Claims Fiduciary needs additional time to process a claim, the Claims Fiduciary may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days, provided that the Claims Fiduciary notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of

extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).

Manner and Content of Notice of Initial Adverse Determination

If the Claims Fiduciary denies a claim, it must provide to you in writing or by electronic communication

- (1) An explanation of the specific reasons for the denial;
- (2) A reference to the Plan provision or insurance contract provision upon which the denial is based;
- (3) A description of any additional information or material that you must provide in order to perfect the claim;
- (4) An explanation of why the additional material or information is necessary;
- (5) Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;
- (6) A statement describing your right to request an external review (or, if applicable, to request a second level appeal), or, if applicable, to bring an action under ERISA Section 502(a);
- (7) 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 your request and without charge); and
- (8) If the adverse determination is based on the Plan's Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances, or (b) a statement that the same will be provided upon your request and without charge.

Any notice of adverse determination also will include the following information:

- (1) Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);
- (2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;
- (3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- (4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and
- (5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

For an adverse determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame, provided that a written or electronic notification in accordance with this section is furnished to you no later than three (3) days after the oral notification.

Internal Review of Initially Denied Claims

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the following procedures:

Health Benefit Claims

You have 180 days after you receive notice of an initial adverse determination within which to request a review of the adverse determination. For a request for a second level appeal, you have 60 days after you receive notice of an adverse determination at the first level of appeal to request a second level appeal of the adverse determination

If you request a review of an adverse determination within the applicable time period, the review will meet the following requirements:

- (1) The Plan will provide a review that does not afford deference to the adverse determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse determination.
- (2) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.
- (3) The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an adverse determination, without regard to whether the advice is relied upon in making the adverse determination on review.
- (4) For a requested review of an adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.
- (5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.
- (6) You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of its determination on review to give you a reasonable opportunity to respond prior to such determination.
- (7) The Plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.
- (8) The Plan will provide you with continued coverage pending the outcome of an internal appeal.

All requests for review of initially denied claims (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 1380
Amherst, NY 14226-1380

Deadline for Internal Review of Initially Denied Claims

- (1) **Urgent Care Claims.** The Plan provides for two levels of appeal for urgent care claims. For each level of appeal, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 36 hours after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).
- (2) **Pre-Service Claims.** The Plan provides for two levels of appeal for a pre-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).
- (3) **Post-Service Claims.** The Plan provides for two levels of appeal for a post-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

Manner and Content of Notice of Decision on Internal Review of Initially Denied Claims. Upon completion of its review of an initial adverse determination (or a first-level appeal adverse determination), the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

- (1) A description of the Plan's decision;
- (2) The specific reasons for the decision;
- (3) The relevant Plan provisions or insurance contract provisions on which its decision is based;
- (4) A statement that you are entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;
- (5) A statement describing your right to request an external review (or, if applicable, to request a second level appeal), or, if applicable, to bring an action under ERISA Section 502(a);
- (6) A statement describing your right to request a second level appeal), or, if applicable, to bring an action under ERISA Section 502(a);
- (7) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request;
- (8) If the adverse determination on review is based on a Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such an explanation will be provided without charge upon request; and
- (9) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and, if your benefit is an insured benefit, your State insurance regulatory agency."

Any notice of adverse determination will include the following information:

- (1) Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

- (2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;
- (3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- (4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and
- (5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Calculation of Time Periods

For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review or a denied claim) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

Adverse Determination

For purposes of the Plan's claim procedures, an "adverse determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Plan's Failure to Follow Procedures

If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy (including any available external review process) under State or Federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

However, the Plan will not be treated as failing to follow its claim procedures and you will not be deemed to have exhausted the Plan's administrative remedies merely because of a failure by the Plan that would be considered (based on applicable regulations) a "*de minimis* violation" that does not cause and is not likely to cause prejudice or harm to you as long as the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. You may request a written explanation of any violation by the Plan of these procedures. If you request such an explanation, the Plan will provide it within 10 days and, if applicable, the explanation will include a specific description of the Plan's reasons for asserting that the violation does not cause the Plan's internal claim procedures to be exhausted. If a court or external review rejects your request for an immediate review (based on a claim that you should be deemed to have exhausted the Plan's internal claim procedures), because the court or external reviewer determines that the "*de minimis* violation" exception applies, the Plan will provide to you a notice of your right to resubmit your internal appeal with a reasonable time (no longer than 10 days) after the court or external reviewer makes such a determination. Any applicable time limit for you to re-file your claim will begin to run when you receive that notice from the Plan.

External Review of Denied Claims

Note: This provision does not apply to dental benefits.

If you have exhausted the Plan's internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan's final adverse determination for certain health benefit claims.

The Plan will provide for an external review process in accordance with Federal law.

Note that the Federal external review process (including the expedited external review process described later in these procedures) is not available for review of all internal adverse determinations. Specifically, Federal external review is not available for review of an internal adverse determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan. The Federal external review process is available only for:

- (1) An adverse determination that involves medical judgment (including, but not limited to determinations based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or the Plan's determination that a treatment is experimental or investigational), as determined by the external reviewer; and
- (2) A rescission of coverage.

For any adverse determination for which external review is available, the Federal external review requirements are as follows:

- (1) You have four (4) months following the date you receive notice of the Plan's final internal adverse determination within which to request an external review. The request for an external review must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 1380
Amherst, NY 14226-1380

- (2) Within five (5) business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one (1) business day after it completes the preliminary review whether the claim is eligible for the external review process:
 - (a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the Employee Benefits Security Administration.
 - (b) If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the four-month deadline described in (1) above to provide the necessary additional information or materials.
- (3) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within five business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.
- (4) The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within ten business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded

on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.

- (5) Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:
- (a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code, and the corresponding meaning for each, and the reason for the previous denial;
 - (b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - (c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;
 - (d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - (e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to you;
 - (f) A statement that judicial review may be available to you; and
 - (g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Expedited External Review

Note: This provision does not apply to dental benefits.

You may request an expedited external review if you have received:

- (1) An initial internal adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal appeal under the Plan's internal claim procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- (2) A final internal adverse determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility.

The following requirements apply to an expedited external review:

- (1) Immediately following the date the Plan receives the external review request the Plan will complete a preliminary review. The Plan will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.
 - (a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the U.S. Department of Health and Human Services Health Insurance Assistance Team (HIAT).

- (b) If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the four-month deadline described in (1) above to provide the necessary additional information or materials.
- (2) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) to make a determination on the request for external review. The Plan will promptly forward to the IRO, by any available expeditious method (e.g. telephone, facsimile, etc.), all information and materials relevant to the final internal adverse determination.
- (3) The IRO must provide notice to the claimant and the Plan (either in writing or orally) as expeditiously as the claimant's medical condition or circumstance require, and no later than 72 hours after it receives the expedited external review request from the Plan. If notice is not provided in writing, the IRO must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO's notice is required to contain the following information:
 - (a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code, and the corresponding meaning for each, and the reason for the previous denial;
 - (b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - (c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;
 - (d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - (e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to you;
 - (f) A statement that judicial review may be available to you; and
 - (g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Effect of External Review Determination

A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable State or Federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Claims Fiduciary has been rendered (or deemed rendered).

Appointment of Authorized Representative

A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Claims Fiduciary or the Third Party Administrator. However,

in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Claims Fiduciary, in writing, to the contrary.

Physical Examinations

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Claims Fiduciary may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

Autopsy

The Plan reserves the right to have an autopsy performed upon any deceased Covered Person whose Illness or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

COORDINATION OF BENEFITS

Benefits Subject to This Provision

This provision applies to all benefits provided under any section of this Plan.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under the Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

- (1) Any primary payer besides the Plan;
- (2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (3) Any policy of insurance from any insurance company or guarantor of a third-party;
- (4) Worker's compensation or other liability insurance company; or
- (5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Vehicle Limitation

When medical payments are available (or, under applicable law should be available) under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification. If medical payments would have been available under a vehicle insurance policy if minimum legally required levels of coverage had been in effect, but the minimum level of coverage was not in effect, the Plan shall pay excess benefits only, determined as if the minimum legally required level of coverage had been in effect at the applicable time.

Allowable Expenses

"Allowable expenses" shall mean any Medically Necessary, Usual and Customary item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as allowable expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

Other Plan

"Other Plan" means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

- (1) Group, blanket, or franchise insurance coverage;
- (2) Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;
- (3) Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, school insurance, or employee benefit organization plans;

- (4) Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;
- (5) Coverage under any Health Maintenance Organization (HMO); or
- (6) Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of injuries arising out of a motor vehicle accident, and any other medical and liability benefits received under any automobile policy.

Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. When this Plan is secondary, this Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. When there is a conflict in the order of benefit determination, this Plan will never pay more than 50% of allowable expenses.

Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim.

- (1) A plan without a coordinating provision will always be the primary plan;
- (2) The plan covering the person directly rather than as an employee's dependent is primary and the other plans are secondary.
- (3) Active/laid-off or Retirees: The plan which covers a person as an active employee (or as that employee's dependent) determines its benefits before the Plan which covers a person as a laid-off or retired employee (or as that employee's dependent). If the Plan which covers that person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.
- (4) Dependent children of parents not separated or divorced, or unmarried parents living together: the plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent, and if as a result the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- (5) Dependent children of separated or divorced parents, or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:
 - (a) The plan of the parent with custody pays first;
 - (b) The plan of the spouse of the parent with custody (the step-parent) pays next;
 - (c) The plan of the parent without custody pays next; and
 - (d) The plan of the spouse of the non-custodial parent pays last.

Notwithstanding the above provisions, if there is a court decree that would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan that covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

- (6) If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If

the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, this Plan may, without notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan is deemed to consent to the release and receipt of such information and agrees to furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery

Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. This Plan may also inadvertently pay benefits that are later found to be greater than the maximum allowable charge. In this case, this Plan may recover the amount of the overpayment from the person or entity to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment.

A Covered Person, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have discretion in deciding whether to obtain payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for any other Injury or Illness) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for any other Injury or Illness) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, most

recent edition of the ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, a Covered Person and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns ("Plan Participants") shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the Plan has not already been reimbursed.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

- (1) In error;
- (2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- (3) Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
- (4) With respect to an ineligible person;
- (5) In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation, Third Party Recovery and Reimbursement provisions; or
- (6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to the Covered Person.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider, and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

Medicaid Coverage

You or your Dependent's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of you or your Dependent. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of such person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

Coordination of Benefits with Medicaid

In all cases, benefits available through a state or federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

Coordination of Benefits with Medicare

When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare. If you did not elect coverage under Medicare Parts A and/or B when eligible, the Plan will be secondary and coordinate with benefits that would have been provided by Medicare.

When you, your Spouse or Dependents (as applicable) are eligible for or entitled to Medicare and covered by the Plan, the Plan at all times will be operated in accordance with any applicable Medicare secondary payer and non-

discrimination rules. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active employees age 65 or over, and rules concerning working disabled individuals (as discussed below).

When Medicare is the primary payor, the Plan will pay secondary to the extent the benefit is a Covered Expense under the Plan (meaning that the Plan will base its payment upon benefits allowable by Medicare).

In accordance with federal law, the following rules apply in determining whether Medicare or Plan coverage is primary health care coverage:

- (1) The Working Aged Rule: Medicare benefits are secondary to benefits payable under the Plan for individuals entitled to Medicare due to being age 65 or over and who have Plan coverage as a result of his or her current employment status (or the current employment status of a Spouse). When you or your Spouse become eligible for Medicare due to the attainment of age 65, you or your Spouse may still be eligible for benefits provided under the Plan based on your current employment status.

If, as a result, you have or your Spouse has primary coverage under the Plan, the Plan will pay the portion of your incurred expenses that are normally covered by the Plan. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are covered expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the Plan. If the expenses are not covered by the Plan but are Medicare-covered expenses, then Medicare will process its payment of the expenses as if you do not have Plan coverage.

- (2) The Working Disabled Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals under age 65 entitled to Medicare on the basis of disability (other than end-stage renal disease) and who are covered under the Plan as a result of current employment status with an employer. That is, if you or your dependents are covered by the Plan based on your current employment status, Medicare benefits are secondary for you or your covered Dependents entitled to Medicare on the basis of disability (other than end-stage renal disease). In this case the Plan is primary.

- (3) End-Stage Renal Disease Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals eligible for or entitled to Medicare benefits on the basis of end-stage renal disease ("ESRD"), for a period not to exceed 30 months generally beginning the first day of the month of eligibility or entitlement to Medicare due to ESRD. (Special rules apply if you were entitled to Medicare based on age or disability prior to becoming eligible for Medicare due to ESRD.) Because an ESRD patient can have up to a three-month wait to obtain Medicare coverage, the Plan's primary payment responsibility may vary up to three months. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the Plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply. Your Human Resources Department can provide you with more detailed information on how this rule works.

Medicare and COBRA

For most COBRA beneficiaries (e.g., the working aged or disabled Medicare beneficiaries), Medicare rules state that Medicare will be primary to COBRA continuation coverage, and this would apply to this Plan's Continuation of Benefits (COBRA) coverage. For an ESRD-related Medicare beneficiary, COBRA continuation coverage (if elected) is generally primary to Medicare during the 30-month coordination period.

Coordination of Benefits with TRICARE

The Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Payment Condition

- (1) The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an Injury, Illness, disease, or disability is caused in whole or in part by, or results from the acts or omissions of you and/or your Dependents, plan beneficiaries, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "coverage").
- (2) The Covered Person, his or her attorney, and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts.
- (3) In the event a Covered Person settles, recovers, or is reimbursed by any coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.
- (4) If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may elect to seek reimbursement, at its discretion.

Subrogation

- (1) As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.
- (2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person may have against any coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
- (3) The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
- (4) If the Covered Person fails to file a claim or pursue damages against:
 - (a) The responsible party, its insurer, or any other source on behalf of that party;
 - (b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - (c) Any policy of insurance from any insurance company or guarantor of a third party;

- (d) Workers' compensation or other liability insurance company; or,
- (e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

- (1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
- (2) No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
- (3) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
- (4) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.
- (5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease or disability.

Excess Insurance

If at the time of Injury, Illness, disease, or disability, there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as provided for under the Plan's "Coordination of Benefits" section. The Plan's benefits shall be excess to:

- (1) The responsible party, its insurer, or any other source on behalf of that party;
- (2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (3) Any policy of insurance from any insurance company or guarantor of a third party;
- (4) Workers' compensation or other liability insurance company or
- (5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person, or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

- (1) It is the Covered Persons' obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - (a) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
 - (b) To provide the Plan with pertinent information regarding the Illness, disease, disability, or Injury, including Accident reports, settlement information and any other requested additional information;
 - (c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - (d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - (e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - (f) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan beneficiary may have against any responsible party or coverage.
- (2) If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.
- (3) The Plan's rights to reimbursement and/or subrogation are in no way dependant upon the Covered Persons' cooperation or adherence to these terms.

Offset

Failure by the Covered Person and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person satisfies his or her obligation.

Minor Status

- (1) In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
- (2) If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable State subrogation laws.

DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section; provided, however that any such capitalized word shall have such meaning when used in any other section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this Plan for that information.

Accident means a non-occupational sudden and unforeseen event, definite as to time and place, or a deliberate act resulting in unforeseen consequences.

Ambulatory Surgical Center means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located and (5) does not provide for overnight accommodations.

Assistant Surgeon means a Physician who actively assists the Physician in charge of a case in performing a Surgical Procedure. Depending on the type of Surgery to be performed, an operating surgeon may have one or two (2) Assistant Surgeons. The technical aspects of the Surgery involved dictate the need for an Assistant Surgeon.

Birthing Center means a place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Calendar Year means January 1 – December 31.

Certificate of Creditable Coverage means a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

Close Relative means a Covered Person's spouse, parent (including step-parents), sibling, child, grandparent, or in-law.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

Coinurance has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

Concurrent Review means the Medical Management Program Administrator will review all Inpatient admissions for a patient's length of stay. The review is based on clinical information received by the Medical Management Program Administrator from the provider or facility.

Congenital Anomaly means a physical developmental defect that is present at birth.

Copay has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

Cosmetic means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

Covered Expense means:

- (1) An item or service listed in the Plan as an eligible medical expense for which the Plan provides coverage.
- (2) For prescription drug expenses, any prescription drugs or medicines eligible for coverage under the Prescription Drug Card Program.
- (3) For dental expenses, an item or service listed in the Plan as an eligible dental expense for which the Plan provides coverage.

Covered Person means, individually, a covered Employee and each of his or her Dependents who are covered under the Plan.

Creditable Coverage means coverage of an individual under a qualified health plan as follows:

- (1) a group health plan;
- (2) health insurance coverage;
- (3) Medicare;
- (4) Medicaid;
- (5) TRICARE;
- (6) an Indian Health Service plan or tribal organization plan;
- (7) a state risk pool coverage;
- (8) a federal employees health insurance coverage;
- (9) a public health plan (this includes plans established or maintained by a state, the U.S. government, a foreign country, a state or federal penitentiary, U.S. Veterans Administration, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the Plan);
- (10) a Peace Corps plan;
- (11) the State Children's Health Insurance Program.

To the extent that further clarification is needed with respect to the sources of Creditable Coverage listed in the prior sentence, please see the complete definition of Creditable Coverage that is set forth in 45 C.F.R. § 146.113(a), which is incorporated by reference.

Custodial Care means care or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Dentist means an individual who is duly licensed to practice dentistry or to perform oral Surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

Dentally Necessary means services or supplies, which are determined by the Plan Administrator to be:

- (1) Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the dental condition, Injury or Illness;
- (2) Provided for the diagnosis or direct care and treatment of the dental condition, Injury or Illness;
- (3) Within standards of good dental practice within the organized dental community;
- (4) Not primarily for the convenience of the Covered Person, the Covered Person's Dentist or another provider; and
- (5) The most appropriate supply or level of service which can safely be provided.

Dependent is a Covered Person, other than the Employee, who is covered by the Plan pursuant to the terms and conditions set forth in the "Eligibility for Participation" section of the Plan.

Durable Medical Equipment means equipment that:

- (1) Can withstand repeated use;
- (2) Is primarily and customarily used to serve a medical purpose;
- (3) Generally is not useful to a person in the absence of an Illness or Injury; and
- (4) Is appropriate for use in the home.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (2) Serious impairment to bodily functions; or
- (3) Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

- (1) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- (2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to Stabilize the individual.

Employee is defined in the "Eligibility for Participation" section of the Plan.

Employer means the Plan Sponsor and each Participating Employer, as applicable.

Endodontic Treatment means procedures for the prevention and treatment of diseases of the dental pulp, pulp chamber, root canal and surrounding periapical structures.

Enrollment Date means the earlier of first day of coverage or, if there is a waiting period, the first day of the eligibility waiting period.

ERISA means the Employee Retirement Income Security Act of 1974, as may be amended from time to time.

Essential Health Benefit has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as may be further defined by the Secretary of the United States Department of Health and Human Services. Essential Health Benefits includes the following general categories and the items and services covered within such categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); Prescription Drugs; rehabilitative and habilitative services and devices; laboratory service; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational: For the purpose of determining eligible expenses under this Plan, a treatment (other than covered Off-Label Drug Use) will be considered by Us to be experimental or investigational if:

- (1) The treatment is governed by the United States Food and Drug Administration ("FDA") and the FDA has not approved the treatment for the particular condition at the time the treatment is provided; or
- (2) The treatment is provided as part of an ongoing Phase I, II, or III clinical trials as defined by the National Institute of Health, National Cancer Institute or the FDA; or
- (3) There is documentation in published U.S. peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity or efficacy of the treatment.

Experimental or Investigational treatment includes any treatment or Hospital confinement that arises from, relates to, or is provided in connection with, the Experimental or Investigational treatment whether or not the treatment or Hospital confinement, on their own, are considered standard of care or Medically Necessary or appropriate.

FMLA means the Family and Medical Leave Act of 1993, as may be amended from time to time.

Genetic Information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility), (2) establishing contribution or premium accounts for coverage under the Plan, and (3) applying the Pre-Existing Condition rule under the Plan.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

Hospice means an agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) has obtained any required state or governmental Certificate of Need approval; (2) provides 24-hour-a-day, seven days-a-week service; (3) is under the direct supervision of a duly qualified Physician; (4) has a nurse coordinator who is a registered nurse (R.N.) with four years of full-time clinical experience, at least two of which involved caring for terminally ill patients; (5) has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) is an agency that has as its primary purpose the provision of hospice services; (7) has a full-time administrator; (8) maintains written records of services provided to the patient; (9) the employees are bonded, and it provides malpractice and

malplacement insurance; (10) is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist, or a certified respiratory therapist; and (12) provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

Hospital means a facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat Illnesses or Injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has 24-hour-a-day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental Disorders or Substance Use Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home or a similar institution.

Illness means a non-occupational bodily disorder, disease, physical sickness, Pregnancy (including childbirth and miscarriage), Mental Disorder, or Substance Use Disorder.

Incurred means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Injury means physical damage to the body, caused by an external force, and which is due directly and independently of all other causes, to an Accident.

Inpatient means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for room and board is made by the Hospital.

Intensive Care Unit means a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit", or an "acute care unit." It has: (1) facilities for special nursing care not available in regular rooms and wards of the Hospital; (2) special life saving equipment which is immediately available at all times; (3) at least two (2) beds for the accommodation of the critically ill; and (4) at least one registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Late Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 31-day eligibility period. A Special Enrollee is not considered a Late Enrollee.

Leave of Absence means a Leave of Absence of an Employee that has been approved by the Plan Sponsor or Participating Employer, as provided for in the Plan Sponsor's or Participating Employer's rules, policies, procedures and practices.

Lifetime Maximum means the maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan may provide for a Lifetime Maximum benefit for specific types of medical treatment. Any Lifetime Maximum will be shown in the applicable Schedule of Benefits or the applicable covered expenses section of the Plan.

Long-Term Acute Care Facility/Hospital (LTACH) means a facility that provides specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour-a-day, seven days a week basis. The severity of the LTACH patient's condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs - such as full service and laboratory, radiology, respiratory care services, etc; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; (5) education for the patient and family to manage their present and future healthcare needs.

Maintenance Therapy means medical and non-medical health-related services that do not seek to cure, or that are provided during periods when the medical condition of the patient is not changing, or does not require continued administration by medical personnel.

Medically Necessary/Medical Necessity: For the purpose of determining eligible expenses under this Plan, a Medically Necessary and appropriate treatment is one that meets all of the following criteria:

- (1) It is recommended and provided by a licensed Physician, Dentist or other medical practitioner who is practicing within the scope of his or her license; and
- (2) It is generally accepted as the standard of medical practice and care for the diagnosis and treatment of the particular condition; and
- (3) It is approved by the FDA, if applicable.

Medicare means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

Morbid Obesity Morbid obesity is defined as (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction.

Non-Participating Provider means a health care practitioner or health care facility that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Off-Label Drug Use: The use of a drug for a purpose other than that for which it was approved by the FDA.

Orthodontic Treatment means the corrective movement of teeth to treat a handicapping malocclusion of the mouth.

Participating Employer means an affiliate of the Plan Sponsor that has adopted the Plan with the consent of the Plan Sponsor.

Participating Provider means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Physician means a legally licensed Physician who is acting within the scope of their license, and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes, but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Speech Therapist, Speech

Pathologist, and Licensed Midwife. An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

Plan means the plan program under the Oaktree Capital Management, L.P. Health and Welfare Plan that provides coverage for medical, dental and prescription drug benefits.

Plan Administrator means the Plan Sponsor. The Plan Sponsor may delegate fiduciary and other responsibilities to the Plan Administrator.

Plan Sponsor means Oaktree Capital Management, L.P., or any successor thereto.

Plan Year means the period from January 1 - December 31 each year.

Prescription Drug means any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, "Caution: federal law prohibits dispensing without prescription," (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Reconstructive Surgery means Surgery that is incidental to an Injury, Illness, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such Surgery as Cosmetic when a physical impairment exists, and the Surgery restores or improves function. Additionally, the fact that a Covered Person may suffer psychological consequences, or socially avoidant behavior as a result of an Injury, Illness, or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

Rehabilitation Facility means a facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute Rehabilitation Facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) twenty-four (24) hour nursing services are available; and (8) the confinement is not for Custodial Care or maintenance care.

Security Standards mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

Semi-Private Room means a Hospital room shared by two or more patients.

Significant Break in Coverage means a period of 63 consecutive days during each of which an individual does not have any Creditable Coverage.

Skilled Nursing Facility is a facility that meets all of the following requirements:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.

- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, developmentally disabled, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Special Enrollee is as an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 31-day eligibility period and who later enrolls in the Plan due to a Special Enrollment Event.

Specialist means a licensed Physician that provides services within the range who provides services to a Covered Person within the range of their specialty (e.g. cardiologist, neurologist, etc.).

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment for the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions and (1) there is inadequate time to effect a safe transfer to another Hospital before delivery or (2) transfer may pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta).

Substance Use Disorder means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

Surgery or Surgical Procedure means any of the following:

- (1) The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
- (2) The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
- (3) The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
- (4) The induction of artificial pneumothorax and the injection of sclerosing solutions;
- (5) Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
- (6) Obstetrical delivery and dilation and curettage; or
- (7) Biopsy.

Third Party Administrator means Meritain Health, Inc., P.O. Box 27267, Minneapolis, MN 55427-0267.

Transplant Facility: A Transplant Facility is defined as:

- (1) A Hospital or facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations to perform a Transplant; and
- (2) For organ transplants: is an approved member of the United Network for Organ Sharing for such Transplant or is approved by Medicare as a transplant facility for such Transplant;
- (3) For unrelated allogeneic bone marrow or stem cell transplants: is a participant in the National Marrow Donor Program;

- (4) For autologous stem cell transplants: is approved to perform such Transplant by: (a) the state where the Transplant is to be performed; or (b) Medicare; or (c) the Foundation for the Accreditation of Hemopoietic Cell Therapy. Outpatient transplant facilities must be similarly approved.

Urgent Care Facility means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse, and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as may be amended from time to time.

Usual and Customary Charge (U&C) means what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any medical or dental complications or unusual circumstances which require additional time, skill or experience. Limitations for Usual and Customary Charges are not applicable to Participating Providers. When the Plan is secondary to Medicare, the Usual and Customary Charge will not exceed the Medicare allowed fee.

PLAN ADMINISTRATION

Delegation of Responsibility

The Plan Sponsor is a named fiduciary of the Plan with full discretionary authority for the control and management of the operation and administration of the Plan. The Plan Sponsor may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan.

Authority to Make Decisions

The Plan is administered by the Plan Administrator in accordance with ERISA. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent's rights, and to decide questions of Plan interpretation and those of fact and law relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that you and/or your Dependent (as applicable) are entitled to them.

The duties of the Plan Administrator include the following:

- (1) To administer the Plan in accordance with its terms;
- (2) To determine all questions of eligibility, status and coverage under the Plan;
- (3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- (4) To make factual findings;
- (5) To decide disputes which may arise relative to a Covered Person's rights;
- (6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- (7) To keep and maintain the Plan documents and all other records pertaining to the Plan;
- (8) To appoint and supervise a Third Party Administrator to pay claims;
- (9) To perform all necessary reporting as required by Federal or State law;
- (10) To establish and communicate procedures to determine whether a child support order or decree is a QMCSO;
- (11) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- (12) To perform each and every function necessary for or related to the Plan's administration.

Amendment or Termination of Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part.

The Plan Sponsor may, in its sole discretion, at any time, amend the Plan, suspend the Plan, or terminate the Plan.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

MISCELLANEOUS INFORMATION

Assignment Of Benefits

No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in ERISA Section 609(a) and in the Plan's QMCSO procedures.

Clerical Error

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to you and/or your Dependents have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity with Applicable Laws

This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of Plan. It is intended that the Plan will conform to the requirements of any applicable federal or state law.

Cost of the Plan

The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan, including, but not limited to, payment of Plan expenses from the Plan Sponsor and Participating Employers' general assets. The amount of contribution (if any) for your coverage or coverage for your Dependents will be determined from time to time by the Plan Sponsor, in its sole discretion.

Interpretation of this Document

The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this Plan applies to eligible or covered Employees and, where appropriate in context, their covered Dependents.

No Contract of Employment

This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan shall be deemed to give any Employee the right to be retained in the service of the Plan Sponsor or Participating Employer or to interfere with the right of the Plan Sponsor or Participating Employer to discharge any Employee at any time.

Release of Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

STATEMENT OF ERISA RIGHTS

As a Covered Person in the Plan, you and your Dependents are entitled to certain rights and protections under ERISA. ERISA provides that you and your eligible Dependents are entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents (other than a Domestic Partner) if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You may experience a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer on request or when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a pre-existing condition exclusion or limitation for 12 months (18 months for Late Enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Covered Persons and beneficiaries. No one, including your Participating Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, a medical child support order or a national medical support notice, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you

are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

HIPAA PRIVACY PRACTICES

The following is a description of certain uses and disclosures that may be made by the Plan of your health information:

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with HIPAA's Standards for Privacy of Individually Identifiable Health Information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

- (1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
- (2) Modifying, amending or terminating the Plan.

"Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan administration purposes, the Plan Sponsor agrees to:

- (1) Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);
- (2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- (3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
- (4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- (5) Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
- (6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
- (7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
- (8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
- (9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

- (a) The Plan Sponsor shall only allow certain named employees, or classes of employees, or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. You may contact the Plan Sponsor for a list of those persons. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.
- (b) In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- (1) The Plan documents have been amended to incorporate the above provisions; and
- (2) The Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the privacy standards.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- (1) Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- (2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
- (3) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and
- (4) Report to the Plan any Security Incident of which it becomes aware.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

Health Information Technology for Economic and Clinical Health (HITECH) Act

The Plan will comply with all applicable requirements of final regulations issued by the Department of Health and Human Services pursuant to Subtitle D of the HITECH Act and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan. If there is any conflict between the requirements of Subtitle D of the HITECH Act, and any provision of this Plan, applicable law will control. Any amendment or revision or authoritative guidance relating to Subtitle D of the HITECH Act is hereby incorporated into the Plan as of the date that the Plan is required to comply with such guidance.

The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan’s compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

GENERAL PLAN INFORMATION

Name of Plan:	The Plan is part of the Oaktree Capital Management, L.P. Health and Welfare Plan
Plan Sponsor: (Named Fiduciary)	Oaktree Capital Management, L.P. 333 S. Grand Avenue, 28th Floor Los Angeles, CA 90071 213-830-6300
Plan Administrator:	Oaktree Capital Management, L.P. 333 S. Grand Avenue, 28th Floor Los Angeles, CA 90071 213-830-6300
Plan Sponsor EIN:	26-0189082
Plan Year:	January 1 - December 31. The records of the Plan are kept on a Calendar Year basis.
Plan Number:	501
Plan Type and Administration Type:	Welfare benefit plan providing medical, dental, and prescription drug benefits. The Plan is administered by a Third Party Administrator.
Plan Funding:	All benefits are paid from the general assets of the Plan Sponsor and each Participating Employer.
Claims Fiduciary/Third Party Administrator:	Meritain Health, Inc. P.O. Box 27267 Minneapolis, MN 55427-0267 1-800-925-2272
COBRA Administrator:	Meritain Health, Inc. P.O. Box 860093 Minneapolis, MN 55486-0093 Fax No.: (763) 852-5079
Medical Management Program Administrator:	Meritain Health Medical Management 7400 West Campus Road, F-510 New Albany, OH 43054-8725 (800) 242-1199
Prescription Drug Program Card Administrator:	Scrip World/CVS Caremark P.O. Box 52010 Phoenix, AZ 85072-2010 866-475-7589 www.caremark.com
Agent for Service of Legal Process:	Oaktree Capital Management, L.P. 333 S. Grand Avenue, 28th Floor Los Angeles, CA 90071 213-830-6300

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

**SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #1
TO THE SUMMARY PLAN DESCRIPTION FOR THE MEDICAL, DENTAL AND
PRESCRIPTION DRUG COMPONENT OF THE
OAKTREE CAPITAL MANAGEMENT, L.P. HEALTH AND WELFARE PLAN
GROUP NO. 12873**

This Summary of Material Modification and Amendment describes changes to the Summary Plan Description effective **January 1, 2013** that Oaktree Capital Management, L.P. (the "Employer") uses to provide its eligible Employees and their eligible Dependents with medical, dental and prescription drug benefits (the "Plan"). These changes are effective as of **January 1, 2013** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Summary Plan Description. Please contact the Plan Administrator if you have any questions regarding the changes described in this Summary of Material Modification.

The Summary Plan Description for the Plan is amended follows:

1. *Number (2) under the list of covered services paid at the Participating Provider level under **General Overview of the Plan** is hereby deleted and replaced with the following:*

GENERAL OVERVIEW OF THE PLAN

Covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level when a:

- (2) Covered Person has an Emergency Medical Condition requiring immediate care. (NOTE: When Emergency Services for an Emergency Medical Condition are rendered by Non-Participating Provider Physicians at a Participating Provider facility, Non-Participating Provider Physician charges will be paid at 100%, without regard to the Usual and Customary Charges, up to a maximum of \$2,500.)

All other provisions of this Plan shall remain unchanged.

**SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #2
TO THE
OAKTREE CAPITAL MANAGEMENT, L.P. HEALTH AND WELFARE PLAN
GROUP NO. 12873**

This Summary of Material Modification and Amendment describes changes to the Oaktree Capital Management, L.P. Health and Welfare Plan effective January 1, 2013. These changes are effective as of **July 1, 2013** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Oaktree Capital Management, L.P. (the "Plan Sponsor") is amending the Oaktree Capital Management, L.P. Health and Welfare Plan (the "Plan") as follows:

1. *The Plan is adding coverage for Qualified Clinical Trial Expenses. As such, the following is hereby added alphabetically under **Eligible Medical Expenses**:*

ELIGIBLE MEDICAL EXPENSES

Qualified Clinical Trial Expenses: Healthcare services for a Covered Person enrolled in a Qualified Clinical Trial that are consistent with the study protocol for the clinical trial and would be covered if the Covered Person did not participate in the Qualified Clinical Trial.

Notwithstanding the above, Qualified Clinical Trial Expenses do not include any of the following:

- (a) the investigational item, device, or service, itself;
 - (b) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Covered Person; or
 - (c) a service that is clearly inconsistent with widely accepted and established standards of care for the Covered Person's particular diagnosis.
2. *Number (22) – Experimental and/or Investigational under **General Exclusions and Limitations** is hereby deleted and replaced with the following:*

GENERAL EXCLUSIONS AND LIMITATIONS

- (22) **Experimental and/or Investigational:** Expenses for any Experimental or Investigational treatment, or for any Hospital confinement or treatment that results from Experimental or Investigational treatment will not be considered eligible, except when such expenses are considered Qualified Clinical Trial Expenses.

3. *The following is hereby added alphabetically under **Definitions**:*

DEFINITIONS

Qualified Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs (a) through (c):

- (a) Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - (1) The National Institutes of Health.
 - (2) The Centers for Disease Control and Prevention.
 - (3) The Agency for Health Care Research and Quality.
 - (4) The Centers for Medicare & Medicaid Services.
 - (5) A cooperative group or center of any of the entities described in clauses (1) through (4) or the Department of Defense or the Department of Veterans Affairs.
 - (6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - (7) Any of the following if the conditions described in paragraph (d), below, are met:
 - (i) The Department of Veterans Affairs.
 - (ii) The Department of Defense.
 - (iii) The Department of Energy.
- (b) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- (c) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- (d) Conditions for Departments. The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines:
 - (1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and
 - (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- (e) Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

All other provisions of this Plan shall remain unchanged.

**SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #3
TO THE SUMMARY PLAN DESCRIPTION FOR THE MEDICAL, DENTAL AND
PRESCRIPTION DRUG COMPONENT OF THE
OAKTREE CAPITAL MANAGEMENT, L.P. HEALTH AND WELFARE PLAN
GROUP NO. 12873**

This Summary of Material Modification and Amendment describes changes to the Summary Plan Description effective **January 1, 2013** that Oaktree Capital Management, L.P. (the "Employer") uses to provide its eligible Employees and their eligible Dependents with medical, dental and prescription drug benefits (the "Plan"). These changes are effective as **specified below** and will remain in effect until amended in writing by the Employer.

This document should be read carefully and attached to the Summary Plan Description. Please contact the Employer if you have any questions regarding the changes described in this Summary of Material Modification.

The Employer is amending the Summary Plan Description for the Plan as follows:

EFFECTIVE SEPTEMBER 23, 2013:

*The **HIPAA Privacy Practices** and **HIPAA Security Practices** sections of the Plan are hereby deleted and replaced with **Exhibit A**, attached hereto and made a part hereof.*

EFFECTIVE OCTOBER 1, 2013:

*Under **Eligible Medical Expenses**, # (11) – **Circumcision** is hereby deleted and replaced with the following:*

ELIGIBLE MEDICAL EXPENSES

- (11) **Circumcision:** Services and supplies related to circumcision. Coverage is limited to circumcisions performed within 6 months of birth, unless delayed due to Medically Necessity. When performed while Hospital confined following birth, circumcisions will be considered as a newborn expense.

All other provisions of this Plan shall remain unchanged.

EXHIBIT A

HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with HIPAA's standards for privacy of individually identifiable health information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

- (1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
- (2) Modifying, amending or terminating the Plan.

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

Except as described under "Disclosure of Summary Health Information to the Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Plan Sponsor" below or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan document, certifies that it agrees to:

- (1) Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- (2) Ensure that any agents, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- (3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- (5) Make available PHI in accordance with section 164.524 of the privacy standards;
- (6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;
- (7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;
- (8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards;
- (9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:

- (a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.
- (b) In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

“Plan administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- (1) The Plan documents have been amended to incorporate the above provisions; and
- (2) The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information

Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include genetic information.

“Underwriting purposes” is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); (3) the application of any preexisting condition exclusion under the Plan; and (4) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, “underwriting purposes” does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

In accordance with HIPAA’s standards for security (the “security standards”), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- (1) Implement and maintain administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.
- (2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
- (3) Ensure that any agent, including any business associate or subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI.
- (4) Report to the Plan any Security Incident of which it becomes aware.
- (5) The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan’s compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the security standards.

**SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #4
TO THE SUMMARY PLAN DESCRIPTION FOR THE MEDICAL, DENTAL AND
PRESCRIPTION DRUG COMPONENT OF THE
OAKTREE CAPITAL MANAGEMENT, L.P. HEALTH AND WELFARE PLAN
GROUP NO. 12873**

This Summary of Material Modification and Amendment describes changes to the Summary Plan Description effective **January 1, 2013** that Oaktree Capital Management, L.P. (the "Employer") uses to provide its eligible Employees and their eligible Dependents with medical, dental and prescription drug benefits (the "Plan"). These changes are effective as of **January 1, 2014** and will remain in effect until amended in writing by the Employer.

This document should be read carefully and attached to the Summary Plan Description. Please contact the Employer if you have any questions regarding the changes described in this Summary of Material Modification.

The Employer is amending the Summary Plan Description for the Plan as follows:

Patient Protection and Affordable Care Act (the "Affordable Care Act")

This Summary of Material Modification and Amendment to the Oaktree Capital Management L.P. Health and Welfare Plan (the "Plan") is adopted to comply with certain provisions of the Patient Protection and Affordable Care Act (the "Affordable Care Act").

1: Cost Sharing Limitation on Out-of-Pocket Maximum

All Covered Expenses apply toward the Plan's established Out-of-Pocket Maximum, with the exception of the services listed below which will never count towards the Out-of-Pocket Maximum.

*Under **General Overview of the Plan**, the **Copay** and **Out-of-Pocket Maximum** sections are hereby deleted and replaced with the following:*

GENERAL OVERVIEW OF THE PLAN

Copay

A Copay is the portion of the medical expense that is your responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible or Coinsurance.

Out-of-Pocket Maximum

An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%. However, as noted below, there are certain expenses which are not counted in determining your Out-of-Pocket Maximum.

The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum, if applicable, is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied; however each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of covered expenses for any Covered Person in the family during the remainder of that Calendar Year.

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, ("non-accumulating expenses") include:

- (1) Charges over Usual and Customary Charges for Non-Participating Providers.
- (2) Any expense that is not a Covered Expense.

Reimbursement for these non-accumulating expenses will continue at the percentage payable shown in the Medical Schedule of Benefits, subject to the Plan maximums.

The Plan will not reimburse any expense that is not an eligible expense. In addition, you must pay any expenses to which you have agreed that are in excess of the Usual and Customary Charges for Non-Participating Providers and any penalties for failure to comply with requirements of the Medical Management Program section of the Plan or any other penalty that is otherwise stated in this Plan. This could result in you having to pay a significant portion of your claim.

Once you have paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Calendar Year, the Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense, or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact your Plan Administrator for assistance.

*Under **Medical Management Program**, the **Penalty** section is hereby deleted and replaced with the following:*

MEDICAL MANAGEMENT PROGRAM

Penalty

If you fail to obtain precertification or fail to notify the Medical Management Program Administrator within the time periods described above, benefits under the Plan will be reduced as follows:

- (1) PPO 100 Plan: Covered Expenses will be reduced by 25% per occurrence.
- (2) PPO 90 Plan: Covered Expenses will be reduced by 25% to a maximum of \$2,000 per Calendar Year.

If the Plan's required review procedures are not followed, a retrospective review will be conducted by the Medical Management Program Administrator to determine if the services provided met all other Plan provisions and requirements. If the review concludes the services were Medically Necessary and would have been approved had the required phone call been made, benefits will be considered, subject to the penalty outlined above. However, any charges not deemed Medically Necessary will be denied.

The **Calendar Year Out-of-Pocket Maximum** section under the **Medical Schedule of Benefits – PPO 90 Plan** and **Medical Schedule of Benefits – PPO 100 Plan** are hereby deleted and replaced with the following:

MEDICAL SCHEDULE OF BENEFITS – PPO 90 PLAN

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible)		
Single	\$500	\$1,000
Family	\$1,500	\$3,000

MEDICAL SCHEDULE OF BENEFITS – PPO 100 PLAN

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible)		
Single	None	\$10,000
Family	None	\$30,000

Under the **Prescription Drug Schedule of Benefits – All Plans**, **Dispense as Written (DAW)** is hereby deleted and replaced with the following:

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – ALL PLANS

Dispense as Written

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Formulary or Non-Formulary Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug in addition to the Formulary or Non-Formulary Drug Copay.

Under **Prescription Drug Card Program**, **Dispense as Written (DAW)** is hereby deleted and replaced with the following:

PRESCRIPTION DRUG CARD PROGRAM

Dispense as Written

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Formulary or Non-Formulary Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug in addition to the Formulary or Non-Formulary Drug Copay.

2: Prohibition on Pre-Existing Conditions

No pre-existing condition limitation shall apply to any covered individual. As such, the **Pre-Existing Condition Limitation** section under the Plan is hereby deleted. All references to Pre-Existing Conditions throughout the Plan are hereby deleted and not replaced. The following provision is added under the **Miscellaneous Information** section of the Plan to read as follows:

MISCELLANEOUS INFORMATION

Certificates of Creditable Coverage

The Plan will automatically provide a Certificate of Creditable Coverage to anyone who loses coverage under the Plan before December 31, 2014. In addition, until December 31, 2014 (or later, to the extent required under applicable law), a Certificate of Creditable Coverage will be provided upon request at any time while the individual is covered under the Plan and up to 24 months after the individual loses coverage under the Plan.

The Plan will make reasonable efforts to collect information about any Dependents and to include that information on the Certificate of Creditable Coverage, but the Plan will not issue an automatic Certificate of Creditable Coverage for Dependents until the Plan has reason to know that a Dependent has lost coverage under the Plan.

All questions about the Certificate of Creditable Coverage may be directed to the Plan Administrator. Refer to the General Plan Information page.

RENEWAL CHANGES

1: Prescription Drug Benefits

The **Prescription Drug Schedule of Benefits – All Plans** section is hereby deleted and replaced with the following:

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – ALL PLANS

BENEFIT DESCRIPTION	BENEFIT
Retail Pharmacy: 30-day supply	
Generic Drug	\$10 Copay, then 100%
Formulary Drug	20% Copay (\$15 minimum, \$25 maximum)
Non-Formulary Drug	20% Copay (\$20 minimum, \$40 maximum)
Specialty Drug	20% Copay (\$25 minimum, \$50 maximum)
Preventive Drug	\$0 Copay (Paid at 100%)
Retail Pharmacy: 90-day supply (Caremark network pharmacies only)	
Generic Drug	\$30 Copay, then 100%
Formulary Drug	20% Copay (\$45 minimum, \$75 maximum)
Non-Formulary Drug	20% Copay (\$60 minimum, \$120 maximum)
Preventive Drug	\$0 Copay (Paid at 100%)
Mail Order Pharmacy: 90-day supply	
Generic Drug	\$10 Copay, then 100%
Formulary Drug	20% Copay (\$15 minimum, \$25 maximum)
Non-Formulary Drug	20% Copay (\$20 minimum, \$40 maximum)
Preventive Drug	\$0 Copay (Paid at 100%)

Dispense as Written

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Formulary or Non-Formulary Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug in addition to the Formulary or Non-Formulary Drug Copay.

Specialty Pharmacy Program

Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs must be obtained directly from a CVS specialty mail order pharmacy. For additional information, please contact the Prescription Drug Card Program Manager.

2: Transplant Program

*Under **Eligible Medical Expenses**, the **SunExcel Transplant Program** section under # (50) – **Transplants (other than those received at an Aetna IOE facility)** is hereby deleted and replaced with the following:*

ELIGIBLE MEDICAL EXPENSES**(50) Transplants (other than those received at an Aetna IOE facility):****Transplant Program**

In addition to the standard transplant benefit as stated above, the following additional covered benefits are available when a Covered Person participates in this special transplant program. This special transplant program is an enhancement to the standard transplant benefit and participation is voluntary.

All other provisions of this Plan shall remain unchanged.

**SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #5
TO THE SUMMARY PLAN DESCRIPTION FOR THE MEDICAL, DENTAL AND
PRESCRIPTION DRUG COMPONENT OF THE
OAKTREE CAPITAL MANAGEMENT, L.P. HEALTH AND WELFARE PLAN
GROUP NO. 12873**

This Summary of Material Modification and Amendment describes changes to the Summary Plan Description effective **January 1, 2013** that Oaktree Capital Management, L.P. (the "Employer") uses to provide its eligible Employees and their eligible Dependents with medical, dental and prescription drug benefits (the "Plan"). These changes are effective as of **January 1, 2014** and will remain in effect until amended in writing by the Employer.

This document should be read carefully and attached to the Summary Plan Description. Please contact the Employer if you have any questions regarding the changes described in this Summary of Material Modification.

The Employer is amending the Summary Plan Description for the Plan as follows:

1. ***Number (5) within the list of covered services paid at the Participating Provider level under the General Overview of the Plan section is hereby added as follows:***

GENERAL OVERVIEW OF THE PLAN

Covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level when a:

- (5) Covered Person is receiving Transitional Care services as defined by the Plan.

2. ***The Plan is adding coverage for Transitional Care. As such, the **Transitional Care** subsection is hereby added under the **General Overview of the Plan** section as follows:***

GENERAL OVERVIEW OF THE PLAN

Transitional Care

Services that are otherwise covered by the Plan and are necessary to ensure continuity of care for treatment in progress by a Physician or other health care practitioner or facility who was, but is no longer, a Participating Provider, provided that all of the following conditions are satisfied:

- (1) The services are limited to treatment in progress for a Covered Person who is:
 - (a) In her second or third trimester of pregnancy;
 - (b) A candidate for organ transplant under active treatment;
 - (c) Receiving mental health or substance abuse treatment;
 - (d) Terminally ill, with an anticipated life expectancy of 6 months or less;
 - (e) Undergoing chemotherapy or radiation therapy for treatment of cancer; or

- (f) Undergoing an active course of treatment for which changing to a different provider would likely cause a significant risk of harm to the Covered Person's health or a significant disruption in the course of treatment;
- (2) The treatment in progress must have begun before the date the Physician or other health care provider or facility ceased to be a Participating Provider;
- (3) The Physician or other health care provider or facility must have ceased to be a Participating Provider for reasons other than quality-related reasons or fraud;
- (4) With respect to the transitional care services, the Physician or other health care provider or facility must have agreed in writing to accept reimbursement at the applicable Usual and Customary Charge, and not to seek payment from the Covered Person for any amount the Covered Person would not be responsible for if the Physician or other health care provider or facility were a Participating Provider;
- (5) The Covered Person must have submitted a request to Meritain for transitional care services by the later of (i) sixty (60) days after the Physician or other health care provider or facility ceased to be a Participating Provider, or (ii) May 1, 2014; and
- (6) Meritain must have approved the request for transitional care.

Transitional care services meeting all of the above conditions will be paid to the Physician or other health care provider or facility based upon the applicable Usual and Customary Charge. You will be responsible for any Copay, Coinsurance and Deductible that would otherwise apply to your use of a Participating Provider and the Out-of-Pocket Maximum will be determined as if the transitional care services were provided by a Participating Provider. Transitional care services will no longer be available after a maximum of 90 days from the date the form is approved or, with respect to pregnancy, through delivery and post-partum care up to 12 weeks. Routine procedures, treatment for stable chronic conditions, minor illnesses and elective Surgical Procedures will not be covered under this section. Any coverage provided under this section will be subject to all other terms of the Plan, including without limitation, limits, requirements, Medical Necessity and maximums of the Plan.

All other provisions of this Plan shall remain unchanged.

**SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #6
TO THE SUMMARY PLAN DESCRIPTION FOR THE MEDICAL, DENTAL AND
PRESCRIPTION DRUG COMPONENT OF THE
OAKTREE CAPITAL MANAGEMENT, L.P. HEALTH AND WELFARE PLAN
GROUP NO. 12873**

This Summary of Material Modification and Amendment describes changes to the Summary Plan Description effective **January 1, 2013** that Oaktree Capital Management, L.P. (the "Employer") uses to provide its eligible Employees and their eligible Dependents with medical, dental and prescription drug benefits (the "Plan"). These changes are effective as of **January 1, 2014** and will remain in effect until amended in writing by the Employer.

This document should be read carefully and attached to the Summary Plan Description. Please contact the Employer if you have any questions regarding the changes described in this Summary of Material Modification.

The Employer is amending the Summary Plan Description for the Plan to clarify the intent of the Plan since January 1, 2012 and the continued intent, as follows:

*The **Calendar Year Out-of-Pocket Maximum** section under the **Medical Schedule of Benefits – PPO 100 Plan** is hereby deleted and replaced with the following:*

MEDICAL SCHEDULE OF BENEFITS – PPO 100 PLAN

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible)		
Single	\$6,350	\$10,000
Family	\$12,700	\$30,000

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Oaktree Capital Management, L.P. has caused this Summary of Material Modification to take effect, be attached to, and form a part of the Summary Plan Description for the Plan.

Authorized Signature

Date

Title

Suzette Ramirez-Carr
Managing Director-Human Resources

Witness

Date

Title

Reiko Hibbett, Vice President, HR

OAKTREE CAPITAL MANAGEMENT LP

Subject: Amendment #7 Effective January 1, 2015, for the Patient Protection and Affordable Care Act (the "Affordable Care Act").

Enclosed you will find your 2015 Benefit Amendment as requested. Based on the information we received, the following assumptions have been made in preparing your amendment:

- You have a combined 100 or more Full-Time Employees and Full-Time Employee equivalents, making you an Applicable Large Employer and subject to the Employer Mandate.
- You will be offering coverage to at least 70% of your Full-Time Employees in 2015 and are working to ensure that coverage is offered to at least 95% of your Full-Time Employees in 2016 (if you are not already satisfying the 95% threshold).
- You will not be offering coverage to any Seasonal Employees (if any) that you employ.
- You have a way to identify all employees who are eligible to participate in your health plan and do not need to utilize a "look-back period" to ensure you are not subject to any applicable penalty.

If any of the above statements are not true, please do not execute this amendment and immediately contact your Client Relationship Manager (CRM) so we can discuss this matter further and ensure your amendment is written to keep your plan in compliance.

As a reminder, any Applicable Large Employer that fails to provide both affordable and comprehensive coverage to their Full-Time Employees will likely be subject to penalties under Internal Revenue Code Section 4980H if one or more of their Full-Time Employee receives subsidized coverage through an exchange.

For more information on the Employer Mandate, including information on how the mandate defines Full-Time Employees and any associated penalties, please refer to our Healthcare Reform Guide.

**SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #7
TO THE
SUMMARY PLAN DESCRIPTION FOR THE MEDICAL, DENTAL AND
PRESCRIPTION DRUG COMPONENT OF THE
OAKTREE CAPITAL MANAGEMENT, L.P.HEALTH AND WELFARE PLAN
GROUP NO. 12873**

This Summary of Material Modification and Amendment describes changes to the Summary Plan Description effective **January 1, 2013** that Oaktree Capital Management, L.P. (the "Employer") uses to provide its eligible Employees and their eligible Dependents with medical, dental and prescription drug benefits (the "Plan"). These changes are effective as of **January 1, 2015** and will remain in effect until amended in writing by the Employer.

This document should be read carefully and attached to the Summary Plan Description. Please contact the Employer if you have any questions regarding the changes described in this Summary of Material Modification.

Patient Protection and Affordable Care Act (the "Affordable Care Act")

This Summary of Material Modification and Amendment to the Plan is adopted, in part, to comply with certain provisions of the Patient Protection and Affordable Care Act (the "Affordable Care Act").

1: Prescription Drug Costs and the Annual Out-of-Pocket Maximum

*The **Calendar Year Out-of-Pocket Maximum** in the **Medical Schedule of Benefits-PPO 90 Plan** is hereby deleted and replaced as shown in the **Renewal Changes** section of this amendment.*

*The **Calendar Year Out-of-Pocket Maximum** in the **Medical Schedule of Benefits-PPO 100 Plan** is hereby deleted and replaced as shown in **Exhibit A**.*

*The **Prescription Drug Schedule of Benefits- All Plans** is respectively renamed **Prescription Drug Schedule of Benefits-PPO 90** and is hereby deleted and replaced as shown in **Exhibit B**.*

*The **Prescription Drug Schedule of Benefits-PPO 100** is hereby added to the plan as shown in **Exhibit C**.*

2: Hours of Service to be Eligible for Coverage

*As such the **Employee Eligibility** section under **Eligibility for Participation** is hereby deleted and replaced with the following:*

ELIGIBILITY FOR PARTICIPATION

Employee Eligibility

An Employee includes a partner of an Employer who provides services to such Employer. A full-time or part-time Employee of the Employer who regularly works 25 or more Hours of Service per week for an Employer or a Participating Employer will be eligible to enroll for coverage under this Plan as of his/her first date of employment. Participation in the Plan will begin as of the first day of the month coinciding with or next following his or her first date of employment, provided all required election and enrollment forms are properly submitted to the Plan Administrator.

You are not eligible to participate in the Plan if you are a temporary, leased or Seasonal Employee, an independent contractor, or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency).

3: Definitions

The following definitions are added alphabetically to the Plan:

DEFINITIONS

Hour(s) of Service mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer (or a related Employer) and each hour for which an Employee is paid, or entitled to payment by the Employer (or a related Employer) for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence, but excluding Hours of Service to the extent that the compensation for those services constitutes income from sources outside the United States or performed as (1) a bona fide volunteer (as defined in Treas. Reg. Section 54.4980H-1(a)(7)) or (2) part of a Federal or State work study program. For purposes of this definition, a related Employer is any entity that must be treated as part of the same “applicable large employer” as the Employer for purposes of Code Section 4980H, as determined at the time that the applicable Hour of Service is performed or credited.

For Employees paid on an hourly basis, an Employer must calculate actual Hours of Service from records of hours worked and hours for which payment is made or due (the “actual method”). For Employees paid on a non-hourly basis, the Employer must calculate Hours of Service based on the actual method or, provided doing so does not substantially understate the Employee’s hours, using an equivalency method where the Employee is credited with either: (1) 8 Hours of Service for each day for which the Employee would be required to be credited with one Hour of Service; or (2) 40 Hours of Service for each week for which the Employee would be required to be credited with at least one Hour of Service.

Seasonal Employee means an Employee who is hired into a position that recurs annually at about the same time each year for which the customary annual employment is 6 months or less.

4: Minimum Essential Coverage

*The following section is hereby added to the **Miscellaneous Information** section of the Plan:*

MISCELLANEOUS INFORMATION

Minimum Essential Coverage

Refer to the Employer’s Summary of Benefits and Coverage (SBC) for determination as to whether the Plan provides “minimum essential coverage” within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance and whether it provides “minimum value” within the meaning of Code Section 36B (c)(2)(C)(ii) and any accompanying regulations or guidance (e.g. the Plan provides at least 60% actuarial value).

RENEWAL CHANGES

1. The **Calendar Year Deductible** and **Calendar Year Out-of-Pocket Maximum**, and **Acupuncture** in the **Medical Schedule of Benefits-PPO 90 Plan** are hereby deleted and replaced as follows:

MEDICAL SCHEDULE OF BENEFITS – PPO 90 PLAN

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
CALENDAR YEAR DEDUCTIBLE		
Single	\$250	\$500
Family	\$500	\$1,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance, Copays and pre-cert penalties – combined with Prescription Drug Card)		
Single	\$1,000	\$2,000
Family	\$2,000	\$4,000
MEDICAL BENEFITS		
Acupuncture	90% after Deductible	70% after Deductible

2. The **Medical Schedule of Benefits- PPO 100 Plan** is hereby deleted and replaced as shown in **Exhibit A**.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Oaktree Capital Management L.P. has caused this Amendment to take effect, be attached to, and form a part of their Health and Welfare Plan.

Authorized Signature

Date

Title

Witness

Date

Title

Martin Boskovich
Managing Director

Suzette Ramirez-Carr
Managing Director-Human Resources

Vice President

EXHIBIT A

MEDICAL SCHEDULE OF BENEFITS - PPO 100 PLAN

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single	\$300	\$600
Family	\$600	\$1,200
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance, Copays and precert penalties – combined with Prescription Drug Card)		
Single	\$6,350	\$12,700
Family	\$12,700	\$30,000
MEDICAL BENEFITS		
Accident Benefit (within 90 days of Accident)	100% of the first \$500 per accident (Deductible waived), then same as any other Illness	100% of the first \$500 per accident (Deductible waived), then same as any other Illness
Acupuncture	\$30 Copay, then 100% Deductible waived	50% after Deductible
Allergy Serums and Injections	100% after Deductible	50% after Deductible
Ambulance Services	100% Deductible waived	100% Deductible waived
Ambulatory Surgical Center	100% after Deductible	50% after Deductible
Birthing Center	100% after Deductible	50% after Deductible
Chiropractic Care/Spinal Manipulation	\$30 Copay, then 100% Deductible waived	50% after Deductible
Diagnostic Testing, X-ray and Lab Services (Office/Clinic Services)	\$20 Copay, then 100% Deductible waived	50% after Deductible
Lab Card Services (Outpatient)	100% Deductible waived	Not Applicable
The use of the Lab Card program offered by Quest Diagnostics is strictly voluntary. If a Covered Person uses the services of Lab Card, the Plan will pay 100% of the eligible charges a Covered Person incurs for outpatient laboratory services, and will waive any of this Plan's Copays, Deductibles and/or Coinsurance requirements. If a Covered Person and/or a Physician elect to use another lab – including the lab in the Physician's office – normal Plan benefits will apply. See the Diagnostic Testing, X-ray and Laboratory Services benefit under Eligible Medical Expenses for further details of this program.		
Durable Medical Equipment (DME)	100% after Deductible	50% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Emergency Services – Emergency Medical Condition	100% Deductible waived	100% Deductible waived
Emergency Services - Non-Emergency Medical Condition	100% after Deductible	50% after Deductible
Home Health Care	100% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	100 visits	
Hospice Care	100% after Deductible	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	100% after Deductible	\$250 Copay per admission, then Deductible, then 50%
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*
Intensive Care Unit	100% after Deductible ICU/CCU Room rate	\$250 Copay per admission, then Deductible, then 50% ICU/CCU Room rate
Miscellaneous Services & Supplies	100% after Deductible	50% after Deductible
Outpatient	100% after Deductible	50% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Maternity (Professional Fees)*		
Preventive prenatal and breastfeeding support (other than lactation consultations)	100% after Deductible	50% after Deductible
Lactation consultations	100% Deductible waived	100% Deductible waived
All other prenatal and postnatal care	100% after Deductible	50% after Deductible
Delivery	100% after Deductible	50% after Deductible
*See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	100% after Deductible	\$250 Copay, then Deductible, then 50%
Outpatient Office Visits	\$20 Copay, then 100% Deductible waived	50% after Deductible
All Other Items and Services	100% after Deductible	50% after Deductible
Emergency Care Ambulance Emergency Services	100% Deductible waived 100% Deductible waived	100% Deductible waived* 100% Deductible waived*
*Paid at Participating Provider level of benefits unless otherwise required by law.		
Outpatient Therapies (e.g., physical, speech, occupational, hearing)	\$20 Copay, then 100% Deductible waived	50% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physician's Services		
Inpatient/Outpatient Services	100% after Deductible	50% after Deductible
Office Visits	\$20 Copay*, then 100% Deductible waived	50% after Deductible
Specialist Visits	\$30 Copay*, then 100% Deductible waived	50% after Deductible
Physician Office Surgery	100% after Deductible	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
Pre-Admission Testing (Outpatient) (performed within 7 days of a scheduled Inpatient admission – if performed in a Physician's office, the office visit Copay will apply)	100% after Deductible	50% after Deductible
Preventive Services		
Preventive Services Under Health Care Reform (includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	100%; Deductible waived	50% after Deductible
Other Preventive Services Includes but is not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or inoculations (including pre-travel and Visa related), well child care, pap smears, mammograms (includes computer assisted diagnosis mammography), colon exams, PSA testing, bone density, CA125, CBC, chest x-ray, complete metabolic panel, CRP, echocardiogram, ferritin, Gardasil, hematology, hepatic panel, iron/TIBC lipid profile, pulmonary function test, routine EKG/ECG, gynecological exams, sigmoidoscopies, sedimentation rate, SMAC-19, T3, TSH, uric acid, ultrasound for breast cancer screening, and vitamin B-12. If a diagnosis is indicated after a preventive exam, the exam will still be payable under the preventive services benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other illness. This benefit is in addition to coverage under the Preventive Services Under Health Care Reform section of the Plan.	100%; Deductible waived	50% after Deductible
Prosthetics	100% after Deductible	50% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	100% after Deductible	50% after Deductible
Combined Calendar Year Maximum Benefit	90 days	

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Temporomandibular Joint Dysfunction (TMJ)	\$20 Copay, then 100% Deductible waived	50% after Deductible
Transplants	100%after Deductible (Aetna IOE Facility)* 50% after Deductible (non-Aetna IOE Facility)	50% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) section of this Plan for a more detailed description of this benefit.		
Urgent Care Facility	\$20 Copay*, then 100% Deductible waived	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
All Other Eligible Medical Expenses	100% after Deductible	50% after Deductible

EXHIBIT B

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – PPO 90

BENEFIT DESCRIPTION	BENEFIT
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Copays - combined with major medical)	
Single	\$1,000
Family	\$2,000
Retail Pharmacy: 30-day supply	
Generic Drug	\$10 Copay, then 100%
Formulary Drug	20% Copay (\$15 minimum, \$40 maximum)
Non-Formulary Drug	20% Copay (\$20 minimum, \$50 maximum)
Specialty Drug	20% Copay (\$25 minimum, \$75 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (Paid at 100%)
Retail Pharmacy: 90-day supply (Caremark network pharmacies only)	
Generic Drug	\$30 Copay, then 100%
Formulary Drug	20% Copay (\$45 minimum, \$120 maximum)
Non-Formulary Drug	20% Copay (\$60 minimum, \$150 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (Paid at 100%)
Mail Order Pharmacy: 90-day supply	
Generic Drug	\$10 Copay, then 100%
Formulary Drug	20% Copay (\$15 minimum, \$40 maximum)
Non-Formulary Drug	20% Copay (\$20 minimum, \$50 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (Paid at 100%)

Dispense as Written

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Formulary or Non-Formulary Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug in addition to the Formulary or Non-Formulary Drug Copay. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Specialty Pharmacy Program

Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs must be obtained directly from a CVS pharmacy. For additional information, please contact the Prescription Drug Card Program Manager.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a paper copy, please contact the Plan Administrator.

EXHIBIT C

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – PPO 100

BENEFIT DESCRIPTION	BENEFIT
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Copays - combined with major medical) Single Family	 \$6,350 \$12,700
Retail Pharmacy: 30-day supply	
Generic Drug	\$10 Copay, then 100%
Formulary Drug	20% Copay (\$15 minimum, \$40 maximum)
Non-Formulary Drug	20% Copay (\$20 minimum, \$50 maximum)
Specialty Drug	20% Copay (\$25 minimum, \$75 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (Paid at 100%)
Retail Pharmacy: 90-day supply (Caremark network pharmacies only)	
Generic Drug	\$30 Copay, then 100%
Formulary Drug	20% Copay (\$45 minimum, \$120 maximum)
Non-Formulary Drug	20% Copay (\$60 minimum, \$150 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (Paid at 100%)
Mail Order Pharmacy: 90-day supply	
Generic Drug	\$10 Copay, then 100%
Formulary Drug	20% Copay (\$15 minimum, \$40 maximum)
Non-Formulary Drug	20% Copay (\$20 minimum, \$50 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (Paid at 100%)

Dispense as Written

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Formulary or Non-Formulary Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug in addition to the Formulary or Non-Formulary Drug Copay. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Specialty Pharmacy Program

Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs must be obtained directly from a CVS pharmacy. For additional information, please contact the Prescription Drug Card Program Manager.

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For a paper copy, please contact the Plan Administrator.



OAKTREE

Flexible Spending Account Plans

OAKTREE CAPITAL MANAGEMENT, L.P.
FLEXIBLE BENEFITS PLAN
Group No. 12873

Plan Document and Summary Plan Description for Flexible Benefits
Originally Effective: January 1, 1995
Last Amended and Restated: January 1, 2014

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PURPOSE OF PLAN; ADOPTION OF THE PLAN DOCUMENT

What is the purpose of the *Plan*?

Oaktree Capital Management, L.P. (the "*Plan Sponsor*") has adopted the Oaktree Capital Management, L.P. Flexible Benefits Plan (the "*Plan*") as set forth herein and as amended from time to time for the exclusive benefit of eligible *employees*. The purpose of this *Plan* is to allow eligible *employees* to pay eligible *qualified medical flexible spending expenses, qualified dependent care flexible spending expenses*, and their share of premiums under the *benefit plan* ("*benefit costs*") using pre-tax dollars.

The intention of the *Plan Sponsor* is that the *Plan* qualifies as a "cafeteria plan" within the meaning of *Code* § 125 and the *Plan* shall be construed in a manner consistent with that Section. The tax implications of this *Plan*, however, are subject to rulings, regulations, and the application of the tax laws of the state and federal government. Although it may anticipate certain tax consequences as being likely, the *Plan Sponsor* does not represent or warrant to any *participant* that any particular tax consequence will result from participation in this *Plan*. By participating in this *Plan*, each *participant* understands and agrees that, in the event the Internal Revenue Service or any state or political subdivision thereof should ever assess or impose any taxes, charges and/or penalties upon any benefits received under the *Plan*, the recipient of the benefit will be responsible for those amounts, without contribution from the *Plan Sponsor*.

This *Plan* is intended not to discriminate as to eligibility or benefits in favor of the prohibited group(s) under *Code* §§ 105 and 125.

Effective date

This plan document and *summary plan description* was most recently amended and restated effective January 1, 2014. Each amendment is effective as of the date set forth therein (the "*effective date*").

Adoption of the summary plan description

The *Plan Sponsor*, as the settlor of the *Plan*, hereby adopts this *summary plan description* as the written description of the *Plan*. This *summary plan description* amends and replaces any prior statement of the benefits contained in the *Plan* or any predecessor to the *Plan*.

IN WITNESS WHEREOF, the *Plan Sponsor* has caused this Plan Document to be executed.

Oaktree Capital Management, L.P.

By: _____

Name: _____

Title: _____

Date: _____

GENERAL PLAN INFORMATION

Name of Plan: The Plan is a part of the Oaktree Capital Management, L.P. Health and Welfare Plan.

Plan Sponsor: Oaktree Capital Management, L.P.
333 S. Grand Avenue, 28th Floor
Los Angeles, CA 90071
213-830-6300

**Plan Administrator:
(Named Fiduciary)** Oaktree Capital Management, L.P.
333 S. Grand Avenue, 28th Floor
Los Angeles, CA 90071
213-830-6300

Plan Sponsor ID No. (EIN): 26-0189082

Plan year: January 1st through December 31st. The records of the Plan are kept on a calendar year basis.

Plan Number: 502

Plan Type: Medical Flexible Spending Account, Dependent Care Flexible Spending Account, and Premium Only Plan under *Code* §§ 106, 125, and 129

**The Plan is administered by a
Third party administrator:** Mertain Health, Inc.
P.O. Box 27847
Minneapolis, MN 55427-0847
800-566-9305

Agent for Service of Process: Oaktree Capital Management, L.P.
Plan Administrator
333 S. Grand Avenue, 28th Floor
Los Angeles, CA 90071
213-830-6300

DEFINITIONS

In this section, you will find the definitions for the italicized words found throughout this *summary plan description*. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section. **These definitions should not be interpreted as indications that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this *summary plan description* for that information.**

“Actively at work” or **“active employment”** means performance by the *employee* of all the regular duties of his occupation at an established business location of the *employer*, or at another location to which he may be required to travel to perform the duties of his employment. An *employee* will be deemed *actively at work* if the *employee* is absent from work due to a health factor.

“Alternate recipient” means any child of a *participant* who is recognized under a *medical child support order* as having a right to benefits under this *Plan* as a *participant’s dependent*. For purposes of the benefits provided under this *Plan*, an *alternate recipient* shall be treated as a *dependent*, but for purposes of reporting and disclosure requirements under *ERISA*, an *alternate recipient* shall have the same status as a *participant*.

“Annual enrollment period” means the period of time designated by the *Plan Sponsor* or *Plan Administrator* each year when eligible *employees* may enroll for participation and make elections under the *Plan* for the following *plan year*.

“Benefit cost” means the cost of premiums for coverage for a *participant*, his spouse and dependent children under the *benefit plan* which a *participant* is required, as a condition of coverage.

“Benefit plan” means the Oaktree Capital Management, L.P. Health and Welfare Plan benefits provided under a group health plan established and maintained by the *Plan Sponsor*, or any successor thereto.

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Code” means the Internal Revenue Code of 1986, as amended.

“Cosmetic surgery” means any procedure that is directed at improving the person’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

“Dependent” has the same meaning, if any, as set forth in the underlying *benefit plan*. For purposes of a *qualifying medical spending account*, *dependent* includes and is limited to (i) a *participant’s spouse* (as determined under federal law), (ii) any person who qualifies as the *participant’s dependent* (as defined in Code Section 152, but disregarding subsections (b)(1), (b)(2), and (d)(1)(B) of section 152) or (iii) the *participant’s child* (as defined in Code Section 152(f)(1), but only if the child is under age 26 on the first day of the applicable calendar year). For purposes of any other *benefit plan* offered under the Plan, if the underlying *benefit plan* provides health coverage for dependents but does not include a definition of *dependent*, *dependent* means (i) a *participant’s spouse*, (ii) a *participant’s child* (as defined in Code Section 152(f)(1)) who is under age 26 or (iii) a *participant’s unmarried child* (as defined in Code Section 152(f)(1)) who is age 26 or older and who, for the applicable calendar year depends on the *participant* for more than half of his or her support, if the child is physically or mentally incapable of self-support, but only if the physical or mental disability commenced before the child reached age 26.

“Dependent care center” means any facility which:

- Complies with all applicable laws and regulations of the state and unit of local government in which it is located;
- Provides care for more than six individuals (other than individuals who reside at the center); and

DEFINITIONS (Continued)

- Receives a fee, payment or grant for providing services for any of such individuals (regardless of whether such facility is operated for profit).

“**Earned income**” means the sum of the amounts set forth in the first section below, but shall exclude the amounts set forth in the second section below:

- *Earned income* includes the following:
 - Wages, salaries, tips and other employee compensation, but only if such amounts are includable as gross income for the taxable year; and
 - The amount of an *employee's* net earnings from self-employment for the taxable year (within the meaning of *Code* § 1402(a)). Such net earnings shall be determined with regard to the deductions allowed to the *employee* under *Code* § 164(f).
- *Earned income* excludes the following:
 - Amounts received under this *Plan* or any other dependent care assistance plan under *Code* § 129;
 - Amounts received as a pension or annuity (within the meaning of *Code* § 32(c)(2));
 - Amounts to which *Code* § 871(a) applies;
 - Amounts attributed to an individual pursuant to community property laws (within the meaning of *Code* § 32(c)(2));
 - Amounts attributable to wages or salary which were reduced pursuant to a written *salary contribution agreement*; and
 - Amounts received for services provided by the *participant* while the *participant* is incarcerated in a penal institution.

“**Employee**” means a person who is an employee of the *employer*, regularly scheduled to work for the *employer* in an employer-employee relationship. The term *employee* does not include any temporary or seasonal worker, independent contractor, or sole proprietor, partner in a partnership or more than 2% shareholder in a subchapter S corporation. Please refer to the section, “Eligibility for Participation,” for information concerning which *employees* are eligible to participate in the *Plan*.

“**Employer(s)**” means Oaktree Capital Management, L.P.

“**ERISA**” means the Employee Retirement Income Security Act of 1974, as amended.

“**FMLA**” means the Family Medical Leave Act of 1993, as amended.

“**FMLA leave**” means a leave of absence which the *employer* is required to extend an *employee* under the provisions of *FMLA*.

“**Grace period**” means the period ending with the 15th day of the third month following the end of a *plan year* in which claims *incurred* for *qualified medical flexible spending expenses* may be considered eligible for reimbursement, subject to any unpaid balance in the applicable *qualified medical flexible spending account* or *qualified dependent care flexible spending account*.

“**Health care expense**” means an expense *incurred* for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. A *health care expense* is not one that is merely beneficial to the general health of an individual.

DEFINITIONS (Continued)

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended, and any regulations thereunder.

“Incurred” means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure that includes several steps or phases of treatment, expenses are *incurred* for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, *qualified medical flexible spending expenses* for the entire procedure or course of treatment are not *incurred* upon commencement of the first stage of the procedure or course of treatment.

“Medical child support order” or “MCSO” means any judgment, decree, or order (including approval of a property settlement agreement) issued by a court of competent jurisdiction that:

- Provides for child support with respect to a *participant’s* child or directs a *participant* to provide coverage under a health *benefit plan* pursuant to a state domestic relations law (including community property law); or
- Enforces a law relating to medical child support described in Section 13822 of the Omnibus Budget Reconciliation Act of 1993 with respect to a group health plan.

“National medical support notice” or “NMSN” means a notice that contains the following information:

- The name of an issuing state agency;
- The name and mailing address (if any) of an *employee* who is a *participant* in the *Plan*;
- The name and mailing address of one or more *alternate recipients* or the name and address of a substituted official or agency that has been substituted for the mailing address of the *alternate recipient(s)*; and
- The identity of an underlying child support order.

“Participant” means an eligible *employee* who is participating in the *Plan*.

“Plan” means the plan program under the Oaktree Capital Management, L.P. Health and Welfare Plan that provides flexible benefits.

“Plan Administrator” means Oaktree Capital Management, L.P.

“Plan Sponsor” means Oaktree Capital Management, L.P.

“Plan year” means the period from January 1st through December 31st each year.

“Premium only plan” means the vehicle through which a *participant* may elect to pay his share of *benefit costs* by reducing his salary and using pre-tax dollars.

“Privacy standards” means the final rule implementing HIPAA’s Standards for Privacy of Individually Identifiable Health Information, as amended.

“Qualified beneficiary” means:

- An individual who, on the day before a *qualifying event*, is a *spouse* or *dependent* child receiving health benefits under the *plan*; or
- In the case of a *qualifying event* resulting in termination of coverage due to termination of employment or reduction in hours, an individual who, on the day before such *qualifying event*, is a *participant*.

DEFINITIONS (Continued)

A newborn child of, an adopted child of, or a child placed for adoption with, a *qualified beneficiary* (as defined in the first bullet above) will be entitled to the same continuation coverage period available to the *qualified beneficiary*; however, such child shall not become a *qualified beneficiary*.

A newborn child or child placed for adoption with a *qualified beneficiary* (as defined in the second bullet above) shall become a *qualified beneficiary* in his own right and shall be entitled to benefits as a *qualified beneficiary*.

A *qualified beneficiary* must notify the *Plan Administrator* within 31 days of the child's birth, adoption or placement for adoption in order to add the child to the continuation coverage.

"Qualified dependent care flexible spending account" means the account established by the *Plan Administrator* on behalf of a *participant* who elects to have amounts withheld from his salary in order to pay *qualified dependent care flexible spending expenses*.

"Qualified dependent care flexible spending expenses" means employment-related dependent care expenses which are eligible for reimbursement under the *Plan* as determined under *Code* §§ 129(e)(1) and 21(b). Such expenses include amounts paid for household services and for the care of *qualifying individuals* enabling the *participant* to be gainfully employed.

"Qualified medical child support order" or "QMCSO" means a *medical child support order* that creates or recognizes the existence of an *alternate recipient's* right to, or assigns to an *alternate recipient* the right to, receive health benefits for which a *participant* or eligible *dependent* is entitled under this *Plan*. In order for such order to be a *qualified medical child support order*, it must clearly specify the following:

- The name and last known mailing address (if any) of a *participant* and the name and mailing address of each such *alternate recipient* covered by the order;
- A reasonable description of the type of coverage to be provided by the *Plan* to each *alternate recipient*, or the manner in which such type of coverage is to be determined;
- The period of coverage to which the order pertains; and
- The name of this *Plan*.

In addition, a *national medical support notice* shall be deemed a *qualified medical child support order* if it:

- Contains the information set forth above in the definition of *national medical support notice*;
- Identifies either the specific type of coverage or all available group health coverage. If the *employer* receives a *national medical support notice* that does not designate either specific types of coverage or all available coverage, the *employer* and the *Plan Administrator* will assume that all are designated;
- Informs the *Plan Administrator* that, if a group health plan has multiple options and a *participant* is not enrolled, the issuing agency will make a selection after the *national medical support notice* is qualified; and
- Specifies that the period of coverage may end for the *alternate recipient(s)* only when similarly situated *dependents* are no longer eligible for coverage under the terms of the *Plan* or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the *Plan* to provide any type or form of benefit, or any option, not otherwise provided to a *participant* and eligible *dependents*, except to the extent necessary to meet the requirements of a state law relating to *medical child support orders*, as described in Social Security Act § 1908 (as added by the Omnibus Budget Reconciliation Act of 1993 § 13822).

DEFINITIONS (Continued)

“Qualified medical flexible spending account” means the account established by the *Plan Administrator* on behalf of the *participant* through which the *participant* may elect to reduce his salary in order to pay *qualified medical flexible spending expenses*.

“Qualified medical flexible spending expenses” means a *health care expense* which is excludable as income according to Code § 105(b). *Qualified medical flexible spending expenses* are not otherwise reimbursable under the *benefit plan* or other plan or by any other entity and may not be claimed as a tax deduction by the *participant*. *Qualified medical flexible spending expenses* do not include the cost of insurance premiums.

“Qualifying individual” means:

- A *dependent* of a *participant* who is under the age of 13;
- A *dependent* of a *participant*, regardless of age, who is physically or mentally incapable of caring for himself and who has the same principal place of abode as the *participant* for more than one-half of the tax year; or
- The *spouse* of a *participant* who is physically or mentally incapable of caring for himself who has the same principal place of abode as the *participant* for more than one-half of the tax year.

“Qualifying event” means any of the following with respect to participation in the *Plan*:

- The termination of coverage due to the death of a *participant*;
- The termination of coverage due to the voluntary or involuntary termination of employment (other than by reason of gross misconduct) or reduction in hours of a *participant*;
- The divorce or legal separation of a *participant* from his *spouse*;
- A *participant*'s entitlement to Medicare coverage; or
- A *dependent* child ceasing to be a *dependent* child.

“Salary contribution agreement” means a written agreement by a *participant* to reduce his salary or wage in order to fund a *qualified medical flexible spending account*, a *qualified dependent care flexible spending account*, or to pay *benefit costs*.

“Security standards” mean the final rule implementing *HIPAA*'s Security Standards for the Protection of *Electronic PHI*, as amended.

“Spouse” has the same meaning, if any, as set forth in the underlying *benefit plan*.

“Student” means an individual who, during each of five calendar months during a taxable year, is a full-time student at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of *students* in attendance at the place where its educational activities are regularly carried on.

“Summary health information” means individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the *Plan*, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

“Summary plan description” means this Plan Document and Summary Plan Description. This *summary plan description* represents both the Plan Document and the Summary Plan Description that is required by *ERISA*.

DEFINITIONS (Continued)

“Third party administrator” means Mertain Health, Inc., P.O. Box 27847, Minneapolis, MN 55427-0847, 800-566-9305.

“Uniformed services” means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

“USERRA” means the Uniformed Services Employment and Re-employment Rights Act of 1994, as amended.

“Waiting period” means an interval of time during which the eligible *employee* is in the continuous, *active employment* of his *employer* before he becomes eligible to participate in the *Plan*.

ELIGIBILITY FOR PARTICIPATION

Am I eligible to participate in the *Plan*?

You are eligible to participate in the *Plan* if you are classified as a regular, full-time or part-time employee. An eligible *employee* may elect to participate on the first day of the month following or coincident with their date of hire.

If you are absent from work due to illness or a medical condition, you will be considered to be *actively at work* during that time period for the purposes of eligibility under this *Plan*.

However, you may elect to make contributions to the Premium Only Plan component only if you participate in the *benefit plan*.

When will my participation begin?

If you are a new *employee*, your entry date for the *Plan* is contingent upon completion of the eligibility requirements outlined above. If you are a new *employee* who is eligible to participate, your entry date is the first date of the month following or coincident with your hire date, provided that you have completed a *salary contribution agreement*. You must complete a proper *salary contribution agreement* within 31 days from your original eligibility date in order to participate in this *Plan* for the *plan year*.

If you are enrolling during an *annual enrollment period*, your entry date will be January 1st following the *annual enrollment period*, provided that you have completed a *salary contribution agreement*.

By completing the *salary contribution agreement* you will be enrolling in this *Plan*. If you participate in the *benefit plan*, you may elect to reduce your salary so that your share of the premiums for the *benefit plan* are paid using pre-tax dollars. Additionally, you may elect to contribute to a *qualified medical flexible spending account* or a *qualified dependent care flexible spending account*. Eligible *employees* who do not participate in this *Plan* may not pay any required contributions to the *benefit plan* with pre-tax dollars, nor may they pay *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses* using pre-tax dollars.

Unless you experience a change in circumstances, as described below, your *salary contribution agreement* will continue in force for that *plan year*, and you will be required to complete a new *salary contribution agreement* for each subsequent *plan year* for which you decide to participate in this *Plan*. However, once you elect to contribute to a *premium only plan* that election will continue to remain in effect from *plan year* to *plan year*, unless you affirmatively elect to cease your participation by so indicating on a new *salary contribution agreement*. If you decide to discontinue your participation in the *premium only plan* during the annual election period, you must affirmatively indicate your intention to do so by completing a new *salary contribution agreement*.

If you do not submit the *salary contribution agreement* to the *Plan Administrator* within 31 days of becoming eligible, or during the *annual enrollment period*, it will be assumed that you have decided not to participate in the *Plan*, and you will not have the opportunity to enroll until the next *annual enrollment period* or following a change in status event described below.

May I make mid-year changes in my *Plan* elections?

Generally, you cannot change your election to participate in the *Plan* or decrease or increase the amount you have elected to contribute to your account(s) once the *plan year* begins. However, you may make a mid-year election change if you experience a change in status event listed below, if that change in status event affects the eligibility for benefits of you, your *spouse*, or your *dependent*, and the election change you make is consistent with the change in status event. Change in status events include:

- Marriage.
- Divorce, legal separation, or annulment.

ELIGIBILITY FOR PARTICIPATION (Continued)

- Birth, adoption, or placement for adoption of a child.
- Death of a *spouse* or *dependent*.
- Termination or commencement of employment by you, your *spouse*, or your *dependent*.
- Reduction or increase in hours of employment by you, your *spouse*, or your *dependent* which results in a change in eligibility under the *Plan* (including a switch from part-time to full-time employment status or vice versa, a strike, or a lockout).
- Place of residence change by you, your *spouse*, or your *dependent*, which results in a change in eligibility.
- Your *dependent* satisfies or ceases to satisfy the requirements for coverage due to attainment of age, or any similar circumstance that would make the *dependent* ineligible under *Code* § 152.
- Commencement or return from an unpaid leave of absence by you, your *spouse*, or your *dependent*.
- A change under another employer plan (including a plan of your employer or of another employer); provided the other employer sponsored plan permits such mid-year election change.
- A change in worksite of you, your *spouse*, or your *dependent*.
- The entitlement to Medicare or Medicaid or the loss of coverage under Medicare or Medicaid by you, your *spouse*, or your *dependent*.
- An election change by the *participant's spouse* or *dependent* (or an election made on behalf of such *dependent* by any other person) under another employer-sponsored plan if the employee's election is on account of and corresponds with the spouse's or dependent's election and either of the following events occur:
 - The election change by the *spouse* or *dependent* satisfies the regulations under *Code* §125 regarding permitted election changes; or
 - The spouse's or dependent's election is for a period of coverage under the plan maintained by the other *employer* which does not correspond to the *plan year* of this *Plan*.

If you experience such a change in status and wish to change your level of coverage, you must submit written notification to the *Plan Administrator* within 31 days of your change in status, as well as a new *salary contribution agreement* reflecting your new contribution elections. The *Plan Administrator* reserves the right to require you to submit proof of any change in status at your expense. The change in coverage becomes effective with the first pay period following the date the written notification is received by the *Plan Administrator*, except that coverage for birth, adoption, or placement for adoption becomes effective the date of the event. Any such change will remain in effect for the remainder of the *plan year*.

- Coverage under Medicaid or under a State Children's Health Insurance Program (CHIP)

If a *participant* did not enroll in the *Plan*, but was otherwise eligible to enroll, he or she will be permitted to later enroll in the *Plan* under one of the following circumstances:

- The *participant* or his or her *dependent* was covered under Medicaid or CHIP at the time of initial enrollment and such coverage subsequently terminates due to loss of eligibility for Medicaid or CHIP; or

ELIGIBILITY FOR PARTICIPATION (Continued)

- The *participant* or his or her *dependent* becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

The *participant* must submit written notification to the *Plan Administrator* and request enrollment in the *Plan* within 60 days after coverage under Medicaid or CHIP terminates or within 60 days after his or her eligibility for a premium assistance subsidy under Medicaid or CHIP is determined, whichever is applicable.

Must the election change be consistent with the change in status?

You will be permitted to change an election during the *plan year* and make a new election for the remainder of the *plan year* only if the change you make is consistent with the event. For example, you can only change your election to contribute to the *premium only plan* or the *qualified medical flexible spending account* if:

- The change in status results in you or your spouse or dependent child, gaining or losing eligibility for health coverage under the *benefit plan* or another health plan of your spouse's or dependent child's employer; and
- The election change corresponds with that gain or loss of coverage.

What if there is a change in the cost of coverage or a significant change in coverage under the *benefit plan* during the *plan year*?

If the *benefit costs* increase or decrease during a *plan year*, the *Plan* may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the affected *participant's* elective contributions for the *premium only plan*.

If there is a significant change in *benefit costs* or a significant change in your coverage under the *benefit plan* (as determined by the *Plan Sponsor*), you may make a corresponding change in your election to participate in the *premium only plan*.

If the cost of your *qualified dependent care flexible spending expenses* significantly increase or decrease (as determined by the *Plan Sponsor*), and such increase or decrease is imposed by your dependent care provider, then you may make a corresponding change in your election to participate in the *dependent care flexible spending account*, provided any amounts paid to your dependent care provider are not considered a payment made to an individual you are related to, as determined in accordance with Code §129(f).

May I continue participation during *FMLA* leave?

If the leave of absence is qualified under *FMLA* you have the option to terminate your participation or continue your participation in the *Plan* and make payments in a manner determined by the *Plan Administrator*, in its sole discretion, from among the following options:

- **Pre-Payment:** You may prepay the contributions that will become due during your *FMLA* leave. Under this option, you may take contributions on a pre-tax basis from any available compensation.
- **Pay-As-You-Go:** You may pay the contributions that become due during your *FMLA* leave on the same schedule as they would otherwise be taken from your pay, on the schedule for *COBRA* payments, under the *employer's* existing rules for payment, or on any other schedule agreed upon by you and the *Plan Administrator*.
- **Catch-Up:** The *Plan Sponsor* may advance the contributions on your behalf, and may recoup the contributions upon your return from *FMLA* leave.

The Pre-Payment and the Catch-Up option may not be offered without also offering the Pay-As-You-Go option.

FMLA leave is treated as a change in status. Therefore, when beginning and/or returning from a qualified leave, you must complete a change in status form.

May I continue participation while I am absent under *USERRA*?

If you are absent from employment because you are in the *uniformed service*, you may elect to continue your coverage under this *Plan* for up to 24 months. To continue your coverage, you must comply with the terms of the *Plan*, including election during the *Plan's annual enrollment period*, and pay your contributions in accordance with the options outlined above for a *participant* who goes on *FMLA leave*.

When does my participation end?

If you terminate employment with the *employer*, your participation in this *Plan* will terminate on the last day you are *actively at work* unless you elect to continue your participation in accordance with the guidelines provided in the “*COBRA continuation coverage*” section. Any *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses* incurred during the *plan year* prior to the date of termination will be reimbursed by the *Plan* in accordance with the guidelines in the section, “*Benefits*.” Your participation in this *Plan* will also terminate if the *employer* decides to terminate this *Plan*, or if you voluntarily decide not to participate under the terms of this *Plan*.

If your participation in this *Plan* terminates because you are no longer eligible to participate, you may either revoke your election to participate and terminate your participation in the *Plan* for the remainder of the *plan year* or continue your participation in accordance with the “*COBRA continuation of coverage*” section. If you do not make payments as required under *COBRA*, it will be assumed that you elected to revoke your participation in this *Plan*.

If your employment terminates, and you return to eligible employment with your *employer* within 30 days, you may rejoin the *Plan* provided that you keep your original election for that *plan year* for the remainder of the *plan year*, as long as the termination was not for the purpose of altering the original election.

If your employment terminates, and you return to eligible employment with your *employer* more than 30 days following termination of your participation, you may rejoin the *Plan* and make a new election after you satisfy the eligibility requirements as long as the termination was not for the purpose of altering the original election.

If you do not complete and file a *salary contribution agreement* during the *annual enrollment period*, your participation will end at the end of the *plan year*.

COBRA continuation of coverage for contributions to a qualified medical flexible spending account

If you are a *participant* in the *Plan*, you, your *spouse* or your *dependents* may be eligible for continued coverage under *COBRA* for contributions made to a *qualified medical flexible spending account*. *COBRA* may give you the right to continue your benefits under a *qualified medical flexible spending account* beyond the date that they might otherwise terminate. The entire cost (plus a reasonable administration fee) must be paid by you. Coverage will end in certain instances, including if you fail to make timely payment of premiums.

When am I eligible for *COBRA*?

You may elect *COBRA* coverage if a *qualifying event* occurs and results in a loss of participation in the *qualified medical flexible spending account* component of the *Plan*, such as:

- The death of the *participant*.
- The termination of the *participant's* employment (other than by reason of the *participant's* gross misconduct) or reduction in the *participant's* hours of employment.
- The divorce or legal separation of the *participant* from his *spouse*.
- A *dependent* child ceases to be a *dependent* under the terms of the *Plan*.
- The *participant* becomes entitled to *Medicare* benefits.

You may not elect *COBRA* to continue coverage under the *premium only plan* or the *qualified dependent care flexible spending account* component of the *Plan*.

ELIGIBILITY FOR PARTICIPATION (Continued)

In the event that the *COBRA* premium for the remainder of the *plan year* exceeds the maximum benefit still available under the *qualified medical flexible spending account* as of the date of the *qualifying event*, the *Plan Administrator* has the option to either not offer *COBRA* continuation coverage, or offer the coverage for the remainder of the *plan year*.

Who may elect *COBRA* coverage?

The following people are known as *qualified beneficiaries* and may elect *COBRA* coverage that will include the benefits to which they were entitled to under the *Plan* on the day before one of the above *qualifying events*:

- The *spouse* or any *dependent* child of the *participant* under the *Plan*.
- The *participant*, if the *qualifying event* is the termination of coverage due to termination of employment or reduction in hours.

If a *dependent* under the *Plan* who is also a *qualified beneficiary* has a newborn child, adopts a child, or a child is placed for adoption with that *dependent*, that child will be entitled to the same *COBRA* coverage period, but will not become a *qualified beneficiary* in his own right.

If you have a newborn child, adopt a child, or a child is placed for adoption with you, that child will become a *qualified beneficiary* in his right.

Who must be notified when a *qualifying event* occurs?

For *qualifying events* such as divorce, legal separation or change in *dependent* status, you must inform the *Plan Administrator* of the event within 60 days of the event. For *qualifying events* such as death, termination or reduction in hours, entitlement to *Medicare*, bankruptcy or failure to return from leave under the *FMLA*, the *employer* has 30 days from the date of the *qualifying event*, or the date that you will lose coverage due to the *qualifying event*, in which to notify the *Plan Administrator*. The *Plan Administrator* has the obligation to furnish you, your *spouse* and your *dependents*, if they are eligible to receive benefits under this *Plan*, with separate, written options to continue coverage within 14 days of receiving notice of the *qualifying event*.

You must notify the *Plan Administrator* within 31 days of a child's birth, adoption, or placement for adoption in order to add the child to the continuation coverage.

What is the cost of *COBRA* coverage?

If you are eligible for and choose to continue coverage, you may be required to pay up to 102% of the actual cost of coverage. This contribution will be on an after-tax basis.

How long may coverage be continued?

If you have experienced a *qualifying event* and have a positive balance in your *qualified medical flexible spending account* at the time of the event (taking into account all claims submitted before the date of the event), you may be eligible to continue participation in this *Plan* under *COBRA*. Your *COBRA* coverage period ends on the last day of the *plan year* in which the *qualifying event* occurs.

What is the effect of the Trade Act?

Two provisions under the Trade Act of 2002 (the "Trade Act") affect the benefits that you may receive under *COBRA*. First, if you lose your job due to international trade agreements you may receive a 65% tax credit for premiums paid for certain types of health insurance, including *COBRA* premiums. Also, if you lose your job due to international trade agreements, you may be allowed an additional 60-day period to elect *COBRA* continuation coverage. If you elect continuation during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the *Plan Administrator* if you believe the *Trade Act* applies to you.

BENEFITS

Qualified medical flexible spending expenses

If you elect to contribute to a *medical flexible spending account*, the *Plan* will reimburse you for *qualified medical flexible spending expenses* which are incurred by you, your *spouse*, or your *dependent* during the *plan year*.

Grace period

To the extent that you have an unpaid balance remaining in your *qualified medical flexible spending account* at the end of the *plan year*, the *Plan* will also reimburse you for *qualified medical flexible spending expenses* which are incurred by you, your *spouse*, or your *dependent* on or before the 15th day of the third calendar month (i.e., 2 ½ month period) immediately following the end of the *plan year*.

Reimbursement for *qualified medical flexible spending expenses* is limited to the annualized amount you elected under your *salary contribution agreement* for the *plan year* to contribute to your *qualified medical flexible spending account*. It is important to keep in mind that you cannot use amounts contributed to a *qualified dependent care flexible spending account* to pay *qualified medical flexible spending expenses*.

What are qualified medical flexible spending expenses?

Qualified medical flexible spending expenses are *health care expenses* which are excludable as income according to Code § 105(b). *Qualified medical flexible spending expenses* may not be otherwise reimbursable under the *benefit plan* or other plan or by any other entity, and they may not be claimed as a tax deduction by the *participant*. *Qualified medical flexible spending expenses* do not include the cost of insurance premiums.

What are examples of qualified and non-qualified medical flexible spending expenses?

The examples listed in this section are intended only to give you a convenient reference to the types of expenses that may be eligible for reimbursement. Determination of *qualified medical flexible spending expenses* will be in accordance with those expenses incurred for medical care, as defined in Code § 213(d) of the Internal Revenue Code as stated at the time the expense is incurred.

Examples of *qualified medical flexible spending expenses* include:

- Acupuncture
- Alcoholism treatment
- Allergy tests and shots
- Ambulance services
- Artificial limbs
- Automobile modifications required by medical conditions
- Birth control pills
- Braille materials (books and magazines)
- Chiropractic services
- Co-payments
- Contact lenses and supplies

BENEFITS (Continued)

- Crutches
- Deductibles on your and your *spouse's* group plan
- Dental services (not cosmetic)
- Dentures
- Eyeglasses, including examination fees
- Healing services
- Hearing aids and batteries
- Hospital costs not covered by a group health plan
- Insulin
- Laboratory fees
- Laetrile by prescription
- Mental health care and fees
- Nurses' fees
- Obstetrical expenses
- Orthodontic services, if medically necessary
- Orthopedic shoes prescribed by a physician
- Osteopaths' fees
- Over-the-counter drugs and medicines are eligible expenses only if they qualify as *health care expenses* and only if you have a valid prescription from a licensed provider
- Oxygen
- Physicians' fees not covered by medical plan
- Podiatrists' fees
- Prescription drugs
- Radial keratotomy
- Ramps required by medical conditions
- Rental of medical equipment

BENEFITS (Continued)

- Routine physical examinations
- Seeing eye dogs and their upkeep
- Smoking cessation programs, only if monitored by a licensed practitioner
- Special communications equipment for the deaf
- Therapeutic care for substance abuse (drug or alcohol)
- Weight loss programs prescribed by physicians for specific health problems
- Wheelchairs

Examples of non-qualified medical flexible spending expenses include:

- *Cosmetic surgery*, except those procedures necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease
- Funeral expenses
- Health insurance premiums
- Massage therapy
- Maternity clothes
- Nursing home expenses
- Over-the-counter drugs and medicines (other than insulin) obtained without a valid prescription from a licensed provider
- Weight loss programs prescribed by physicians for general health improvement

This list should not be considered all-inclusive, and determination of non-qualified expenses will be in accordance with Internal Revenue *Code* §§ 105(b) and 213(d) as stated at the time the expense is *incurred*.

Qualified dependent care flexible spending expenses

If you have elected to contribute to a *dependent care flexible spending account*, the *Plan* will reimburse you for *qualified dependent care flexible spending expenses* which are *incurred* by you during the *plan year*.

Reimbursement for *qualified dependent care flexible spending expenses* is limited to the annualized amount you elected under your *salary contribution agreement* to contribute to a *qualified dependent care flexible spending account* for the *plan year*. It is important to keep in mind that you cannot use amounts contributed to a *qualified medical flexible spending account* to pay *qualified dependent care flexible spending expenses*.

What are qualified dependent care flexible spending expenses?

Qualified dependent care flexible spending expenses are employment-related *dependent care* expenses eligible for reimbursement under the *Plan* as determined under *Code* §§ 129(e) (1) and 21(b).

Such expenses include amounts paid for daycare and other household services and for the care of *qualifying individuals* enabling you to be gainfully employed.

What are examples of qualified and non-qualified dependent care flexible spending expenses?

The examples listed in this section are intended only to give you a convenient reference to the types of expenses that may be eligible for reimbursement. Determination of eligible expenses will be in accordance with *Code* §§ 21 and 129, as stated at the time the expense is *incurred*.

Examples of *qualified dependent care flexible spending expenses* include:

- Fees of a licensed *dependent care center* that cares for your *dependent* child.
- After-school care expenses.
- Wages of individuals who provide care inside or outside your home for your *dependent* child under age 13 or a *qualifying individual* over age 13 who is incapable of self-support.
- Federal and state employment taxes you pay for an individual you employ to provide *dependent* care.
- Day camps.
- Pre-school or nursery school tuition.

Examples of *non-qualified dependent care flexible spending expenses* include:

- Educational expenses for a child in kindergarten or above.
- Transportation, entertainment, food or clothing unless such items are incidental and cannot be separated from the cost of the care provided.
- Household expenses that are not attributable at least in part to the care of the *qualifying individual*.
- Expenses for a camp where a *qualifying individual* spends the night.

This list should not be considered all-inclusive, and determination of non-qualified expenses will be in accordance with *Code* §§ 21 and 129, as stated at the time the expense is *incurred*.

Benefit costs

By electing to participate in the *premium only plan*, your portion of the *benefit costs* will be taken out of your salary and paid using pre-tax dollars.

Must I file a claim for benefits under the *premium only plan*?

No, it is not necessary to file a claim for benefits under a *premium only plan*. Amounts taken out of your pay pursuant to a *salary contribution agreement* will automatically be used to pay your *benefit costs*.

How do I file a claim for benefits under a *qualified medical flexible spending account*?

You must submit a properly completed and documented claim to:

Mertain Health, Inc.
P.O. Box 27847
Minneapolis, MN 55427-0847
800-566-9305

It must include the following information:

- The name of the person or persons on whose behalf the expenses have been *incurred*.

BENEFITS (Continued)

- The nature of the expenses *incurred* (that is, a description of the services or supplies being claimed).
- The date the expenses were *incurred*.
- Evidence that such expenses have not otherwise been paid, or are otherwise payable, through any coverage (insured or self-insured) or fee-for-service arrangement, or from any other source.

The claim must include written evidence from an independent third party documenting the above information. If the expenses are not reimbursable under any *benefit plan*, include a copy of the provider's statement that shows the date(s) of service, an explanation of services, and the name of the provider, along with a copy of the Explanation of Benefits or denial letter(s) from the *benefit plan(s)*. Canceled checks or balance due statements are not acceptable.

You must also submit a signed statement in a form furnished and approved by the *Plan Administrator* certifying that the expenses for which you are seeking reimbursement are expenses which you believe in good faith are eligible for reimbursement under the *Plan*.

The *Plan Administrator*, in its sole discretion, reserves the right to verify to its satisfaction the eligibility of all claimed expenses prior to reimbursement and to refuse to reimburse any amounts that it determines are not eligible for reimbursement under this *Plan*.

The *Plan* will pay properly submitted claims for reimbursement at such intervals as the *Plan Administrator* may consider appropriate.

How do I file a claim for benefits under a *qualified dependent care flexible spending account*?

You must submit a properly completed and documented claim to:

Mertain Health, Inc.
P.O. Box 27847
Minneapolis, MN 55427-0847
800-566-9305

It must include the following information:

- A list of names of the eligible *qualifying individual* for whom the expenses were *incurred*, the ages of such *qualifying individual*, and the *qualifying individual's* relationship to you.
- If any of the services were performed outside of your home for a *qualifying individual* incapable of caring for him, a statement as to whether the *qualifying individual* regularly spends at least eight hours a day in the your home.
- If any of the services are performed for a *qualifying individual* who is physically or mentally incapable of caring for himself, a statement to that effect.
- A description of the nature and dates of performance of the qualifying services for which cost you wish to be reimbursed.
- A description of the relationship, if any, to you of the person or persons who performed the services.
- A statement indicating that you will include on your federal income tax return the name, address, and (except in the case of a tax-exempt *dependent care facility*) the taxpayer identification number of the provider of the services.
- If you are married, a statement as to whether you plan to file a separate federal income tax return from your *spouse*.

BENEFITS (Continued)

- If you are married, and your *spouse* is employed, a statement of your *spouse's* compensation.
- If you are married and your *spouse* is not employed, a statement that your *spouse* is incapacitated, or that your *spouse* is a *student*, and indicating the months of the year during which the *spouse* attends an educational institution on a full-time basis.
- A statement as to the amount, if any, of tax-exempt *dependent* care assistance benefits received from any other employer for you or your *spouse* during the *plan year*.
- Evidence of indebtedness or payment by you to the third party who performed the services.
- Written evidence, signed by an independent third party stating that the expenses have been *incurred*, the amount of such expenses, the date of services, and such other information as the *Plan Administrator* in its sole discretion may request.
- A statement as to where the services were performed.
- A statement indicating whether the services are necessary to enable you to be gainfully employed.
- A statement that the expenses have not been reimbursed and are not reimbursable under any other plan or by any other entity.
- A statement, signed by you and in such form as determined by the *Plan Administrator*, certifying that the expenses for which reimbursement is sought are expenses that you believe in good faith are eligible for reimbursement.

You must also attach a paid receipt from your day care provider or from the individual who provides the care. The social security number or the federal tax identification number of the provider **must** appear on the claim form or receipt. The individual who provides the care cannot be your *spouse* or a *dependent* under the age of 19.

The *Plan Administrator*, in its sole discretion, reserves the right to verify to its satisfaction the eligibility of all claimed expenses prior to reimbursement and to refuse to reimburse any amounts that it determines are not eligible for reimbursement under this *Plan*.

The *Plan* will pay properly submitted claims for reimbursement at such intervals as the *Plan Administrator* may consider appropriate.

Is there a time limit for filing claims?

All claims for reimbursement for *qualified medical flexible spending account* or for *qualified dependent care flexible spending account* must be submitted no later than June 15th following the end of the *plan year*, or if earlier, 90 days following the date you cease to participate in the *Plan* or the claims will be denied.

Is there a minimum claim amount?

The minimum amount you may submit for reimbursement for *qualified medical flexible spending expenses* is \$25, except at the end of the *grace period* in which the expense was *incurred*.

The minimum amount you may submit for reimbursement for *qualified dependent care flexible expenses* is \$25, except at the end of the *plan year* in which the expense was *incurred*.

What if my *qualified medical flexible spending account* balance or my *qualified dependent care flexible spending account* balance is less than my claim?

Reimbursement for *qualified medical flexible spending expenses* is limited to the annualized amount that you have elected to reduce your salary or wages and contribute to the *qualified medical flexible spending account* for the *plan year* under a valid *salary contribution agreement*. Reimbursement for *qualified dependent care flexible spending*

BENEFITS (Continued)

expenses is limited to the amount that you have elected to reduce your salary or wages to contribute to the *qualified dependent care flexible spending account* for the *plan year* under a valid *salary contribution agreement* for that *plan year*.

To the extent that it is not used to pay claims, the amount of contributions to your *qualified medical flexible spending account* will accumulate throughout the *plan year*. If you submit an eligible claim during the *plan year* in an amount that exceeds your current *qualified medical flexible spending account* balance, the *Plan* will reimburse your claim expense up to the annualized amount of contributions, less any amounts already used to pay claims. Your salary contribution election amount will continue to be taken for the remainder of the *plan year*.

To the extent that it is not used to pay claims, the amount of contributions to your *qualified dependent care flexible spending account* will also accumulate throughout the *plan year*. If you submit an eligible claim during the *plan year* in an amount that exceeds your current *qualified dependent care flexible spending account* balance, the *Plan* will reimburse your claim expense up to the total amount of contributions in your *qualified dependent care flexible spending account*, less any amounts already used to pay claims.

As contribution amounts become available in your *qualified dependent care flexible spending account*, they may be used to reimburse any unpaid balance from a previously submitted *qualified dependent care flexible spending expense*. At no time during the *plan year* will the amount paid for claims exceed the amount of contributions made to the *qualified dependent care flexible spending account*.

In no instance can amounts contributed to a *qualified medical flexible spending account* be used to reimburse *qualified dependent care flexible spending expenses*, or vice versa.

What if I do not use all of the money in my *qualified medical flexible spending account* or my *qualified dependent care flexible spending account*?

You have until the end of the *grace period* to file any *qualified medical flexible spending expenses* and you have 90 days following the end of the *plan year* to file any *qualified dependent care flexible spending expenses incurred* for that year, or if earlier 90 days following the date you cease to participate in the *Plan*, or the claims will be denied. If you fail to file for reimbursement within this time limit, or if you did not incur enough *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses* to meet your annual salary contribution amount to each respective account, you forfeit any unused funds in your account.

FUNDING

How is a *qualified medical flexible spending account* funded?

Your *qualified medical flexible spending account* is funded by the amounts that you elect to contribute to the account by executing a valid *salary contribution agreement*. *Qualified medical flexible spending expenses* will be reimbursed to you to the extent of the amount you have elected to reduce your salary or wages for the *plan year* under a valid *salary contribution agreement*.

Your annual salary or wage may be reduced in an amount not to exceed \$5,000 or any other amount established by the *Plan Sponsor* for each *plan year* and communicated to you prior to the *annual enrollment period*. The salary contribution amount elected will be funded pro rata over the number of consecutive pay periods in the *plan year*.

The *Plan Administrator* will establish an individual *qualified medical flexible spending account* for each *participant*, and will credit to each *participant's* account the salary contribution amounts elected.

The *Plan* will reimburse you for *qualified medical flexible spending expenses* as described in the “Benefits” section.

How is a *qualified dependent care flexible spending account* funded?

Your *qualified medical flexible spending account* is funded by the amounts that you elect to contribute to the account by executing a valid *salary contribution agreement*. *Qualified medical flexible spending expenses* will be reimbursed to you to the extent of the amount you have elected to reduce your salary or wages for the *plan year* under a valid *salary contribution agreement*.

Your annual salary or wage may be reduced in an amount not to exceed \$2,500 or any other amount established by the *Plan Sponsor* for each *plan year* and communicated to you prior to the *annual enrollment period*. The salary contribution amount elected will be funded pro rata over the number of consecutive pay periods in the *plan year*.

The *Plan Administrator* will establish an individual *qualified medical flexible spending account* for each *participant*, and will credit to each *participant's* account the salary contribution amounts elected.

The *Plan* will reimburse you for *qualified medical flexible spending expenses* as described in the “Benefits” section.

How much can I elect to contribute to my *qualified dependent care flexible spending account*?

If you are not married you may contribute up to \$5,000 to a *qualified dependent care flexible spending account*; however, in the event that your *earned income* is less than \$5,000, you may contribute an amount not to exceed your *earned income* for the taxable year. If you begin participation in the middle of the *plan year* you may contribute up to \$5,000 less any amounts that you have contributed to any other *qualified dependent care flexible spending account* during the *plan year*.

If you are married, you may contribute an amount up to the lesser of the *earned income* of you or your *spouse*, not to exceed \$5,000. If you and your *spouse* file separate tax returns, you may elect to contribute an amount up to \$2,500 to the *Plan*. If you begin participation in the middle of the *plan year* you may contribute up to \$5,000, or \$2,500 if you and your *spouse* file separately, less any amounts that you have contributed to any other *qualified dependent care flexible spending account* during the *plan year*.

If your *spouse* is a full-time *student*, for each month in which he is a full-time *student*, for the purpose of determining how much you can contribute under this plan, he will be considered to be gainfully employed, and to have *earned income* of not less than \$250 per month if there is one *qualifying individual* with respect to the taxpayer for the taxable year and not less than \$500 per month if there are two or more *qualifying individuals* with respect to the taxpayer for the taxable year.

If your *spouse* is a *qualifying individual*, for the purpose of determining how much you can contribute under this plan, he will be considered to be gainfully employed, and to have *earned income* of not less than \$250 per month if

FUNDING (Continued)

there is one *qualifying individual* with respect to the taxpayer for the taxable year and not less than \$500 per month if there are two or more *qualifying individuals* with respect to the taxpayer for the taxable year.

Minimum Election Amounts

The minimum amount you may elect to contribute to your *qualified medical flexible spending account* is \$50 each year.

The minimum amount you may elect to contribute to your *qualified dependent care flexible spending account* is \$50 each year.

How is a *premium only plan* funded?

The *premium only plan* is funded by your contributions under a *salary contribution agreement* with the *employer*. The contribution amounts paid under the *salary contribution agreement* will be adjusted automatically during a *plan year* to reflect changes in the *benefit cost*.

Order of funding

The total salary contribution amount for this *Plan* for any one time period may not exceed the amount of your salary or wages for that period. In the event that the total elected amount exceeds your salary or wages for a period, amounts available shall be used to fund the accounts in the following order: the *premium only plan*, the *qualified medical flexible spending account*, then the *qualified dependent care flexible spending account*. The total salary contribution amount will be reduced by the amount it exceeds your salary or wages for that period; however, future contributions will be adjusted to compensate for such reduction.

Accounting

The *Plan Administrator* will maintain complete records of all amounts to be credited as a contribution or debited as a reimbursement of *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses* on behalf of each *participant*. All contributions will be held as part of the general assets of the *employer*. No trust fund will be established and no other segregation or investment of assets will be made to maintain accounts of contributions under this *Plan*.

SALARY CONTRIBUTION AND DISCRIMINATION

Election period for salary contribution

In order to fund a *qualified medical flexible spending account*, *qualified dependent care flexible spending account*, or the *benefit costs* for a *premium only plan* for a *plan year*, you must complete and file with the *Plan Administrator* an appropriate *salary contribution agreement* election form as described in the section, “Eligibility for Participation.” You should consider carefully the amount of salary contribution you elect for each account because you will forfeit any unused amount at the end of the *plan year* or *grace period*.

Termination, revocation, or amendment of salary contribution elections

Your *salary contribution agreement* election for a *plan year* will terminate at the end of the *plan year*. You must make an affirmative election for a new salary contribution for each *plan year*. However, with regard to the *premium only plan* only, once you have elected to participate in a *premium only plan*, your participation will continue from *plan year* to *plan year* unless you affirmatively elect to cancel or change that participation by completing the appropriate salary contribution agreement.

Termination, revocation, or amendment of salary contribution elections may only be made by you in accordance with the section, “Eligibility for Participation,” “May I make mid-year changes?”.

Forfeiture of salary contribution amounts

If you fail to claim any amounts in the *qualified medical flexible spending account*, *qualified dependent care flexible spending account*, or *premium only plan* within the time limits specified in the section, “Benefits,” “Is There a Time Limit for Filing Claims?,” such amounts will be forfeited by you to the *Plan Sponsor*.

Reduction of salary contribution elections to prevent discrimination in favor of prohibited group(s)

The *Plan* is intended not to discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and benefits and is intended to comply in this respect with the requirements of the *Code*. If, in the judgment of the *Plan Administrator*, the operation of the *Plan* in any *plan year* would result in such discrimination, then the *Plan Administrator* shall select and exclude from coverage under the *Plan* such highly compensated individuals who are *participants*, and/or reduce contributions under the *Plan* by highly compensated individuals who are *participants*, to the extent necessary to assure that, in the judgment of the *Plan Administrator*, the *Plan* does not discriminate.

The *Plan Administrator* will have the full authority to reduce the salary contribution elections of *participants* who are members of the prohibited group(s) under *Code* §§ 105(h) or 125, to the extent necessary to prevent the *Plan* from discriminating in favor of such prohibited group(s).

Determination of noncompliance

In the event that a determination is made that all or any part of the contributions to the *Plan* do not qualify as non-taxable contributions to a “cafeteria plan” under *Code* § 125, the affected contributions made by any *participant* will be treated as salary, and any unpaid balance in the *qualified medical flexible spending expense account*, the *qualified dependent care flexible spending account* and the *premium only plan* will be returned to the *participant*. The *participant* must pay:

- Any state or federal income taxes due with respect to such amount, together with any interest or penalties imposed;
- The *participant's* share (as determined in good faith by the *employer*) of any applicable FICA or FUTA contributions which would have been withheld from such amounts by the *employer* had such amounts been treated as salary and not as *qualified medical flexible spending expenses*, *qualified dependent care flexible spending expenses*, or *benefit costs*; and
- An amount (as determined in good faith by the *employer*) equal to the portion of any applicable penalties and interest payable by the *employer* as the result of the failure to withhold and pay such amounts to the appropriate payee allocable to the *participant*.

PLAN ADMINISTRATION

Who has the authority to make decisions in connection with the *Plan*?

The *Plan* is administered by the *Plan Administrator* in accordance with *ERISA*. The *Plan Administrator* has retained the services of the *third party administrator* to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* will appoint a new *Plan Administrator* as soon as reasonably possible.

The *Plan Administrator* will administer this *Plan* in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this *Plan* that the *Plan Administrator* will have maximum legal discretionary authority to construe and interpret the terms and provisions of the *Plan*, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are not *qualified medical flexible spending expenses*, *qualified dependent care flexible spending expenses*, or *benefit costs*), to decide disputes which may arise relative to a *participant's* rights, and to decide questions of *Plan* interpretation and those of fact relating to the *Plan*. The decisions of the *Plan Administrator* as to the facts related to any claim for benefits and the meaning and intent of any provision of the *Plan*, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this *Plan* will be paid only if the *Plan Administrator* decides, in its discretion, that the *participant* is entitled to them.

The duties of the *Plan Administrator* include the following:

- To administer the *Plan* in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the *Plan*;
- To interpret the *Plan*, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a *participant's* rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain the *Plan* documents and all other records pertaining to the *Plan*;
- To appoint and supervise a *third party administrator* to pay claims;
- To perform all necessary reporting as required by *ERISA*;
- To establish and communicate procedures to determine whether *MCSOs* and *NMSNs* are *QMCSOs*;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the *Plan's* administration.

May changes be made to the *Plan*?

The *Plan Sponsor* expects to maintain this *Plan* indefinitely; however, the *Plan Sponsor* may, in its sole discretion, at any time, amend, suspend or terminate the *Plan* in whole or in part. This includes amending the benefits under the *Plan*.

PLAN ADMINISTRATION (Continued)

Any such amendment, suspension or termination shall be adopted by whomever has the authority to take such action with respect to the Oaktree Capital Management, L.P. Health and Welfare Plan. Notice shall be provided as required by *ERISA*.

If the *Plan* is terminated, the rights of *participants* are limited to expenses *incurred* before termination. All amendments to this *Plan* shall become effective as of a date established by the *Plan Sponsor*.

Additional operating rules

A *participant's* salary contribution amount will not be subject to federal income tax withholding or to applicable Social Security (FICA or FUTA) tax withholding. Salary contribution amounts will not be subject to any state income tax withholding unless otherwise prohibited by applicable state law.

Salary contribution amounts under this *Plan* shall not reduce salary or wage for purposes of any other employer sponsored employee benefit programs unless the provisions of those programs otherwise provide.

MISCELLANEOUS INFORMATION

Will the *Plan* release my information to anyone?

For the purpose of determining the applicability of and implementing the terms of these benefits, the *Plan Administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *participant* for benefits under this *Plan*. In so acting, the *Plan Administrator* shall be free from any liability that may arise with regard to such action; however, the *Plan Administrator* at all times will comply with the *privacy standards*. Any *participant* claiming benefits under this *Plan* shall furnish to the *Plan Administrator* such information as may be necessary to implement this provision.

What if the *Plan* makes an error?

Clerical errors made on the records of the *Plan* and delays in making entries on such records shall not invalidate participation nor cause participation to be in force or to continue in force. Rather, the effective dates of participation shall be determined solely in accordance with the provisions of this *Plan* regardless of whether any contributions with respect to *participants* have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

In the event that it has determined that the *Plan Administrator* has mistakenly reimbursed an expense which did not qualify under the terms of the *Plan*, the *Plan Administrator* may adjust your pay and appropriately credit the *qualified medical flexible spending account*, *qualified dependent care flexible spending account* or *premium only plan*.

Will the *Plan* conform with applicable laws?

This *Plan* shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this *Plan*, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the *Plan Administrator* to pay claims that are otherwise limited or excluded under this *Plan*, such payments will be considered as being in accordance with the terms of this *summary plan description*. It is intended that the *Plan* will conform to the requirements of *ERISA*, as it applies to employee welfare plans, as well as any other applicable law.

When must legal actions be filed?

Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within one year after the *benefit costs*, *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses* are *incurred* or are alleged to have been *incurred*. Any limitation on actions regarding claims for benefits shall be as provided in the section entitled "Claims Review Procedures."

What constitutes a fraudulent claim?

The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of participation under this *Plan*:

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person other than you, your *spouse* or your *dependent* according to the *Plan*;
- Attempting to file a claim for services that were not rendered or drugs or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the *Plan*; or
- Providing any false or misleading information to the *Plan*.

How will this document be interpreted?

The use of masculine pronouns in this *summary plan description* shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this *summary plan description* are used for convenience of reference only. *Participants* are advised not to rely on any provision because of the heading.

The use of the words, “you” and “your” throughout this *summary plan description* applies to *participants*.

Is this *summary plan description* a contract between the employer and *participants*?

This *summary plan description* and any amendments and other *Plan* documents constitute the terms and provisions of coverage under this *Plan*. The *summary plan description* shall not be deemed to constitute a contract of any type between the *employer* and any *participant* or to be consideration for, or an inducement or condition of, the employment of any *employee*. Nothing in this *summary plan description* shall be deemed to give any *employee* the right to be retained in the service of the *employer* or to interfere with the right of the *employer* to discharge any *employee* at any time.

May I appoint an authorized representative?

A *participant* is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. To appoint such a representative, the *participant* must complete a form which can be obtained from the *Plan Administrator* or the *third party administrator*. In the event a *participant* designates an authorized representative, all future communications from the *Plan* will be with the representative, rather than the *participant*, unless the *participant* directs the *Plan Administrator*, in writing, to the contrary.

How will the *Plan* pay benefits?

All benefits under this *Plan* are payable, in U.S. Dollars, to the *participant* or, if appropriate, the *alternate recipient*. In the event of the death or incapacity of a *participant* and in the absence of written evidence to this *Plan* of the qualification of a guardian for his estate, the *Plan Administrator* may, in its sole discretion, make any and all payments due under the *plan* to the individual or institution which, in the opinion of the *Plan Administrator*, is or was providing the care and support of such *participant*.

What if my claim is for non-U.S. Providers?

Qualified medical flexible spending expenses and *qualified dependent care flexible spending expenses* for care, supplies or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a “*non-U.S. provider*”) may be reimbursed under the following conditions:

- The *participant* is responsible for making all payments to *non-U.S. providers*, and submitting receipts to the *Plan* for reimbursement;
- Benefit payments will be determined by the *Plan* based upon the exchange rate in effect on the *incurred* date;
- The *non-U.S. provider* shall be subject to, and in compliance with, all requirements under *Code* § 105; and
- Claims for benefits must be submitted to the *Plan* in English.

How will the *Plan* recover payments made in error?

Whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the *participant* on whose behalf such payment was made.

A *participant*, *spouse*, *dependent*, provider, another benefit plan, insurer, or any other person or entity who receives a payment made in error under the terms of the *Plan*, shall return the amount of such erroneous payment to the *Plan* within 30 days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

MISCELLANEOUS INFORMATION (Continued)

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the *Plan* for an erroneous payment and whether such payment shall be reimbursed in a lump sum or other arrangement, as agreed.

Participants accepting payment from the *Plan*, in consideration of such payments, agree to be bound by the terms of this *Plan* and agree to submit claims for reimbursement in strict accordance with the requirements of this *Plan*. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the *Plan* shall be entitled to recover its litigation costs and actual attorneys' fees incurred.

How will the *Plan* handle medical child support orders?

The *Plan Administrator* shall adhere to the terms of any *medical child support order* that satisfies the requirements of this section and Section 609 of ERISA. The *Plan Administrator* shall enroll for immediate coverage under this *Plan* any *alternate recipient* who is the subject of a *medical child support order* that is a *qualified medical support order* if such an individual is not already covered by the *Plan* as a *dependent*.

The *Plan Administrator* shall promptly notify the *participant* and each *alternate recipient* of:

- The receipt of a *medical child support order* by the *Plan*; and
- The *Plan*'s procedures for determining the qualified status of *medical child support orders*.

Within a reasonable period after receipt of a *medical child support order*, the *Plan Administrator* shall determine whether such order is a *qualified medical child support order* and shall notify the *participant* and each *alternate recipient* of such determination. If the *participant* or any affected *alternate recipient* disagrees with the determinations of the *Plan Administrator*, the disagreeing party shall be treated as a claimant and the claims procedure provided in the section, "Claims Review Procedures," of the *Plan* shall be followed. The *Plan Administrator* may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the *Plan*.

Upon receiving a *national medical support notice*, the *Plan Administrator* shall:

- Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the *Plan*, and if so:
 - Whether the child is covered under the *Plan*; and
 - Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
- Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the *Plan Administrator* shall:

- Establish reasonable, written procedures for determining the qualified status of a *medical child support order* or a *national medical support notice*; and
- Permit any *alternate recipient* to designate a representative for receipt of copies of the notices that are sent to the *alternate recipient* with respect to the order.

Payments made under this *Plan* pursuant to a *medical child support order* described in this section in reimbursement for expenses paid by the *alternate recipient* or the *alternate recipient*'s custodial parent or legal guardian shall be made to the *alternate recipient* or the *alternate recipient*'s custodial parent or legal guardian.

CLAIMS REVIEW PROCEDURE

Upon receipt of complete information, the claim will be deemed to be filed with the *Plan*. The *Plan Administrator* will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the *Plan Administrator* within 45 days from receipt by the *participant* of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of claim decisions

The *Plan Administrator* shall notify you, in accordance with the provisions set forth below, of any adverse benefit determination within the following timeframes:

- If you have provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If you have not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then you will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then you will be notified of the determination by a date agreed to by you and the *Plan Administrator*.

Extensions. This period may be extended by the *Plan* for up to 15 days, provided that the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notifies you, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the *Plan*.

Notification of an adverse benefit determination

The *Plan Administrator* shall provide you with a notice, either in writing or electronically, containing the following information:

- A reference to the specific portion(s) of the *summary plan description* upon which a denial is based;
- Specific reason(s) for a denial;
- A description of any additional information necessary for you to perfect the claim and an explanation of why such information is necessary;
- A description of the *Plan's* review procedures and the time limits applicable to the procedures, including a statement of your right to bring a civil action under section 502(a) of *ERISA* following an adverse benefit determination on final review;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the *Plan* did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to you, free of charge, upon request); and

CLAIMS REVIEW PROCEDURE (Continued)

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or *experimental*), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to your medical circumstances, or a statement that such explanation will be provided to you, free of charge, upon request.

Appeal of adverse benefit determinations

Full and fair review of all claims

In cases where a claim for benefits is denied, in whole or in part, and you believe the claim has been denied wrongly, you may appeal the denial and review pertinent documents. The claims procedures of this *Plan* provide you with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the *Plan* provides:

- You at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
- You the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the *Plan*, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the *Plan* fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- For the identification of medical or vocational experts whose advice was obtained on behalf of the *Plan* in connection with a claim, even if the *Plan* did not rely upon their advice; and
- That you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits in possession of the *Plan Administrator* or the *third party administrator*; information regarding any voluntary appeals procedures offered by the *Plan*; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to your medical circumstances.

Requirements for appeal

You must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, your appeal must be addressed as follows and mailed or faxed as follows:

Meritain Health, Inc.
Appeals Department
P.O. Box 1380
Amherst, NY 14226-1380

It shall be your responsibility to submit proof that the claim for benefits is covered and payable under the provisions of the *Plan*. Any appeal must include:

CLAIMS REVIEW PROCEDURE (Continued)

- The name of the *participant*;
- The *participant's* social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the *participant* will lose the right to raise factual arguments and theories which support this claim if the *participant* fails to include them in the appeal;**
- The claim amount
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the *participant* has which indicates that the *participant* is entitled to benefits under the *Plan*.

If you provide all of the required information, it may be that the expenses will be eligible for payment under the *Plan*.

Timing of notification of benefit determination on review

- The *Plan Administrator* shall notify you of the *Plan's* benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the appeal.
- Calculating Time Periods. The period of time within which the *Plan's* determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this *Plan*, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and content of notification of adverse benefit determination on review

The *Plan Administrator* shall provide you with notification, in writing or electronically, of a *Plan's* adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;
- Reference to the specific portion(s) of the *summary plan description* on which the denial is based;
- The identity of any medical or vocational experts consulted in connection with the claim, even if the *Plan* did not rely upon their advice;
- A statement that the *participant* 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 *participant's* claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;
- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to your medical circumstances, will be provided free of charge upon request;

CLAIMS REVIEW PROCEDURE (Continued)

- A statement of your right to bring an action under section 502(a) of *ERISA*, following an adverse benefit determination on final review; and
- The following statement: “You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.”

Furnishing documents in the event of an adverse determination

In the case of an adverse benefit determination on review, the *Plan Administrator* shall provide you access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to “Manner and Content of Notification of Adverse Benefit Determination on Review” as appropriate.

Decision on review to be final

If, for any reason, you do not receive a written response to the appeal within the appropriate time period set forth above, you may assume that the appeal has been denied. The decision by the *Plan Administrator* or other appropriate named fiduciary of the *Plan* on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the *Plan* must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 365 days after the *Plan*’s claim review procedures have been exhausted.**

HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with HIPAA's standards for privacy of individually identifiable health information (the "privacy standards"), the *plan* may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
2. Modifying, amending or terminating the *plan*.

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the *plan*, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

Except as described under "Disclosure of Summary Health Information to the Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Plan Sponsor" below or under the terms of an applicable individual authorization, the *plan* may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the *plan* to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the *plan*. The Plan Sponsor by formally adopting this *plan* document, certifies that it agrees to:

- Not use or further disclose PHI other than as permitted or required by the *plan* or as required by law;
- Ensure that any agents, to whom the Plan Sponsor provides PHI received from the *plan* agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the *plan* any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- Make available PHI in accordance with section 164.524 of the privacy standards;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;
- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the *plan* with part 164, subpart E, of the privacy standards;
- If feasible, return or destroy all PHI received from the *plan* that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

- Ensure that adequate separation between the *plan* and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:
 - The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the *plan*.
 - In the event any of the individuals described in (a) above do not comply with the provisions of the *plan* documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

“Plan administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- The *plan* documents have been amended to incorporate the above provisions; and
- The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the *plan* may disclose to the Plan Sponsor information on whether an individual is participating in the *plan* or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the *plan*.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for *plan administration* Functions

In accordance with HIPAA’s standards for security (the “security standards”), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- Implement and maintain administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the *plan*.
- Ensure that adequate separation between the *plan* and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
- Ensure that any agent, including any business associate or subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained or transmitted on behalf of the *plan*, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI.
- Report to the *plan* any Security Incident of which it becomes aware.
- The Plan Sponsor will promptly report to the *plan* any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the *plan’s* compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the security standards.

STATEMENT OF *ERISA* RIGHTS

As a *participant* in the *Plan*, you are entitled to certain rights and protections under *ERISA*. *ERISA* provides that all *participants* are entitled to:

Receive information about your *Plan* and benefits

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

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

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

Continue group health *Plan* coverage

Continue health care coverage in the *qualified medical flexible spending account* for yourself, *spouse* or *dependents* if there is a loss of coverage under the *Plan* as a result of a *qualifying event*. You or your *dependents* may have to pay for such coverage. Review this *summary plan description* and the documents governing the *Plan* on the rules governing your *COBRA* continuation coverage rights.

Prudent actions by *Plan* fiduciaries

In addition to creating rights for *participants*, *ERISA* imposes duties upon the people who are responsible for the operation of the *Plan*. The people who operate your *Plan*, called "fiduciaries" of the *Plan*, have a duty to do so prudently and in the interest of you and other *participants* and beneficiaries. No one, including your *employer* or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce your rights

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

Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of *Plan* documents or the latest annual report from the *Plan* and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the *Plan Administrator* to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the *Plan Administrator*. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the *Plan's* decision or lack thereof concerning the qualified status of a domestic relations order, a *medical child support order* or a *national medical support notice*, you may file suit in Federal court. If it should happen that *Plan* fiduciaries misuse the *Plan's* money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

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

**SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #1
to the
OAKTREE CAPITAL MANAGEMENT, L.P. FLEXIBLE BENEFITS PLAN
GROUP NO. 12873**

This Summary of Material Modification describes changes to the Plan Document and Summary Plan Description for the benefit program the Plan Sponsor uses to provide its eligible employees with flexible benefits (the “Plan”). The Plan is part of the Oaktree Capital Management, L.P. Health and Welfare Plan. These changes are effective as of **February 1, 2014** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Oaktree Capital Management, L.P. (the “Plan Sponsor”) is amending the Plan Document and Summary Plan Description for the benefit program the Plan Sponsor uses to provide its eligible employees with flexible benefits (the “Plan”) as follows:

*First paragraph under the “What is the purpose of the Plan?” section under **Purpose of Plan; Adoption of the Plan Document** is hereby deleted and replaced with the following:*

PURPOSE OF PLAN; ADOPTION OF THE PLAN DOCUMENT

What is the purpose of the Plan?

Oaktree Capital Management, L.P. (the “Plan Sponsor”) has adopted this Plan Document and Summary Plan Description for the benefit program the Plan Sponsor uses to provide its eligible *employees* with flexible benefits as set forth herein and as amended from time to time.. The purpose of this *Plan* is to allow eligible *employees* to pay eligible *qualified medical flexible spending expenses, qualified dependent care flexible spending expenses*, and their share of premiums under the *benefit plan* (“*benefit costs*”) using pre-tax dollars. The Plan is a part of the Oaktree Capital Management, L.P. Health and Welfare Plan.

*The definition of the “Active military reservist” is hereby added alphabetically under **Definitions** as follows:*

DEFINITIONS

“***Active military reservist***” means a *participant* who was (by reason of being a member of a reserve component, as defined in Section 101 of Title 37 of the United States Code) ordered or called to active duty for a period in excess of 179 days or for an indefinite period of time.

*The definitions of “COBRA”, “Code”, “Employee” and “Grace Period” under **Definitions** are hereby deleted and replaced with the following:*

DEFINITIONS

“***COBRA***” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and any regulations thereunder.

“***Code***” means the Internal Revenue Code of 1986, as amended, and any regulations thereunder.

“Employee” means a person who is an employee of the *employer*, regularly scheduled to work for the *employer* in an employer-employee relationship. The term *employee* does not include (a) any contract, temporary, casual or seasonal worker, (b) any individual who performs services for the *employer* but who is paid by a temporary or other employment or staffing agency, whether or not such individuals are determined to be common-law employees of the *employer*, (c) any leased employee (including, but not limited, to those individuals defined in Code Section 414(n)), (d) any independent contractor, (e) any sole proprietor, (f) any partner in a partnership, (g) any more than 2% shareholder in a subchapter S corporation, or (h) any employee covered under a collective-bargaining agreement. Please refer to the section, “Eligibility for Participation,” for information concerning which *employees* are eligible to participate in the *Plan*.

“Grace period” means the period ending with the 15th day of the third month following the end of a *plan year* in which claims *incurred* for *qualified medical flexible spending expenses* may be considered eligible for reimbursement, subject to any unpaid balance in the applicable *qualified medical flexible spending account*.

The following bullet is hereby added under “May I make mid-year changes in my Plan elections?” section under Eligibility for Participation as follows:

ELIGIBILITY FOR PARTICIPATION

May I make mid-year changes in my Plan elections?

Generally, you cannot change your election to participate in the *Plan* or decrease or increase the amount you have elected to contribute to your account(s) once the *plan year* begins. However, you may make a mid-year election change if you experience a change in status event listed below, if that change in status event affects the eligibility for benefits of you, your *spouse*, or your *dependent*, and the election change you make is consistent with the change in status event. Change in status events include:

- A judgment, decree, or order (“order”) resulting from a divorce, legal separation, annulment, or change in legal custody, including a *qualified medical child support order*, that requires accident or health coverage for your child or dependent foster child. If such an event occurs, the *plan administrator* may change your election to provide coverage for the child if the order requires coverage under a health plan. Also, you may make an election change to cancel coverage for the child if the order requires your *spouse*, former spouse or another individual to provide coverage.

The “What if I do not use all of the money in my qualified medical flexible spending account or my qualified dependent care flexible spending account?” section under Benefits is hereby deleted and replaced with the following:

BENEFITS

What if I do not use all of the money in my qualified medical flexible spending account or my qualified dependent care flexible spending account?

All claims for reimbursement for *qualified medical flexible spending expenses* or for *qualified dependent care flexible spending expenses* must be submitted no later than June 15th following the end of the *plan year*, or if earlier, 90 days following the date you cease to participate in the *Plan* or the claims will be denied.

The “What special rules apply if I am an active military reservist?” and the “What if a claim is overpaid or determined not to be qualified for payment?” sections are hereby added under Benefits as follows:

BENEFITS

What special rules apply if I am an active military reservist?

If you are an *active military reservist*, you shall be entitled to receive, upon request, a distribution of the balance in your *qualified medical flexible spending account* that would otherwise be forfeited. The following rules apply to any request for such a distribution (a “Qualified Reservist Distribution” or “QRD”):

- You must make the request during the period beginning on the date you are ordered or called to active duty and ending on the last day of the *grace period* for the *plan year* in which such order or call to active duty occurred;
- The amount of the QRD shall be equal to the amount contributed to your *qualified medical flexible spending account* as of the date the QRD request is received, less any requests for reimbursements for *qualified medical flexible spending expenses* received as of such date; and
- The distribution shall be made after the QRD request is made and no later than the last date that reimbursements could otherwise be made under the *Plan* for the *plan year* in which such order or call to active duty occurred.

QRDs shall be administered in accordance with the Heroes Earnings Assistance and Relief Tax Act of 2008 (“HEART Act”) and any regulations or other guidance issued thereunder.

What if a claim is overpaid or determined not to qualify for payment?

If the *plan administrator* finds that any claims have been paid that are not for *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses*, or were otherwise overpaid, you are required to refund any amount so identified to the appropriate account. If you fail to promptly refund the overpayment to the *Plan*, the amount may be withheld from your wages or other compensation to the extent permitted by law. In addition, the *Plan* reserves the right to credit the overpayment against other *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses* that you may submit until the overpayment refund is satisfied.

The “Is there a time limit for filing claims?” section under **Benefits** is hereby deleted and replaced with the following:

BENEFITS

Is there a time limit for filing claims?

All claims for reimbursement for *qualified medical flexible spending expenses* or for *qualified dependent care flexible spending expenses* must be submitted no later than June 15th following the end of the *plan year*, or if earlier, 90 days following the date you cease to participate in the *Plan* or the claims will be denied. You will cease to participate in the *Plan* on the date you terminate employment, unless you elect COBRA coverage for your *qualified medical spending account*.

The “How is a qualified medical flexible spending account funded?” and the “How is a qualified dependent care flexible spending account funded?” sections under *Funding* are hereby deleted and replaced with the following:

FUNDING

How is a qualified medical flexible spending account funded?

Your *qualified medical flexible spending account* is funded by the amounts that you elect to contribute to the account by executing a valid *salary contribution agreement*. *Qualified medical flexible spending expenses* will be reimbursed to you to the extent of the amount you have elected to reduce your salary or wages for the *plan year* under a valid *salary contribution agreement*.

Your annual salary or wage may be reduced in an amount not to exceed \$2,500 or any other amount established by the *Plan Sponsor* for each *plan year* and communicated to you prior to the *annual enrollment period*. The salary contribution amount elected will be funded pro rata over the number of consecutive pay periods in the *plan year*.

The *Plan Administrator* will establish an individual *qualified medical flexible spending account* for each *participant*, and will credit to each *participant’s* account the salary contribution amounts elected.

The *Plan* will reimburse you for *qualified medical flexible spending expenses* as described in the “Benefits” section.

How is a *qualified dependent care flexible spending account* funded?

Qualified dependent care flexible spending expenses will be reimbursed to you to the extent of the amount you have elected to reduce your salary or wages for the *plan year* under a valid *salary contribution agreement*, not to exceed the amount in your account at the time reimbursement is requested.

Your salary or wage may be reduced in an amount you elected under the *salary contribution agreement*. The salary contribution amount elected will be funded pro rata over the number of consecutive pay periods in the *plan year*.

The *Plan Administrator* will establish an individual *qualified dependent care flexible spending account* for you and will credit to your account the amounts taken out of your pay for each pay period.

The *Plan* will reimburse you for *qualified dependent care flexible spending expenses* as described in the “Benefits” section.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Oaktree Capital Management, L.P. caused this Amendment to take effect, be attached to, and form a part of their Plan.

Authorized Signature _____ Date _____

Title _____

Witness	Date
---------	------

Title



OAKTREE

Master Plan

Summary Plan Description

OAKTREE CAPITAL MANAGEMENT, L.P.

HEALTH AND WELFARE PLAN

**OAKTREE CAPITAL MANAGEMENT, L.P.
HEALTH AND WELFARE PLAN**

ARTICLE 1

INTRODUCTION

1.1 **Nature and Purpose, History.** Oaktree Capital Management, L.P. (the “Company”) sponsors the OAKTREE CAPITAL MANAGEMENT, L.P. HEALTH AND WELFARE PLAN (the “Plan”) to provide group medical, group-term life insurance, long-term disability and accidental death and dismemberment benefits for eligible Employees of the Company and their eligible Dependents. The purpose of the Plan document is to set forth certain rules and policies applicable to the Plan.

1.2 **Effective Date, Plan Year.** The effective date of the Plan restatement is January 1, 2014. A “Plan Year” is the 12-month period beginning on January 1 and ending on the next following December 31.

1.3 **Plan Programs.** The benefit programs offered under the Plan are governed by the terms and conditions contained herein and in the Plan Program Documents. These Plan Programs, and Plan Program Documents, are subject to change from time to time.

ARTICLE 2

DEFINITIONS

2.1 **General.** For purposes of the Plan, the following terms, when capitalized, will have the following meanings; provided, however, that if any term is defined in one of the Plan Program Documents listed on Schedule B, then, except as otherwise provided herein, the definition set forth in such Plan Program Document shall govern for purposes of that benefit to the extent inconsistent with the definition set forth herein.

2.2 **“Affordable Care Act”** means the Patient Protection and Affordable Care Act, as amended and supplemented by the Health Care and Education Reconciliation Act of 2010, and the regulations issued thereunder.

2.3 **“COBRA”** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and the regulations issued thereunder.

2.4 **“Code”** means the Internal Revenue Code of 1986, as amended from time to time, and the regulations issued thereunder.

2.5 **“Company”** shall have the meaning set forth in Section 1.1.

2.6 **“Dependent”** means a child, spouse, domestic partner or other dependent of an Employee as defined under the Plan Program Document applicable to such Employee. Notwithstanding any definition to the contrary, the Plan shall provide benefits in accordance with

the applicable requirements of any qualified medical child support order (“QMCSO”), as defined in ERISA.

2.7 **“Eligible Employee”** means an Employee of a Participating Employer who is eligible to participate in the Plan under the terms of the Plan and applicable Plan Program Document.

2.8 **“Employee”** means an employee of a Participating Employer who is (a) considered an employee of the Participating Employer for federal income tax purposes or (b) on an approved leave of absence for which Plan benefits are available under the terms of a Plan Program Document, until such person terminates employment. An Employee includes a partner who is treated as an employee under Section 401(c)(1) of the Code with respect to a Participating Employer. A temporary or leased Employee shall not be eligible to participate in the Plan. The term “Employee” may also include a former Employee of a Participating Employer, but only to the extent expressly provided in the Plan Program Document(s) applicable to the group of Employees of which such former Employee is a member. Notwithstanding anything herein or in a Plan Program Document to the contrary, an individual is not an Employee during any period during which the individual is classified by an Employer as an independent contractor or as any other status in which the person is not treated as a common law employee of an Employer or Participating Employer for purposes of withholding of taxes, regardless of the correct legal status of the individual and regardless of whether a court or administrative agency subsequently determines that such individual is a common law employee. The previous sentence applies to all periods of such service of an individual who is subsequently reclassified as an employee, whether reclassification is retroactive or prospective.

2.9 **“Employer”** means the Company and any affiliate of the Company that adopts the Plan with the consent of the Company in accordance with Section 7.1.

2.10 **“ERISA”** means the Employee Retirement Income Security Act of 1974, as amended from time to time, and the regulations issued thereunder.

2.11 **“FMLA”** means the Family and Medical Leave Act of 1993, as amended from time to time, and the regulations issued thereunder.

2.12 **“HIPAA”** means the Health Insurance Accountability and Portability Act of 1996, as amended from time to time, and the regulations issued thereunder.

2.13 **“HMO”** means a health maintenance organization.

2.14 **“NMHPA”** means the Newborns’ and Mothers’ Health Protection Act of 1996, as amended from time to time, and any regulations issued thereunder.

2.15 **“Participant”** means any Eligible Employee or eligible Dependent who becomes covered under the Plan in accordance with Article 3.

2.16 **“Participating Employer”** means the Company and any other entity that adopts the Plan, with the approval of the Company and of such other entity, if applicable, pursuant to Section 7.1, by executing documents evidencing such intent and consent. “Participating

Employer” includes any successor(s) to a Participating Employer, whether by merger, consolidation or otherwise.

2.17 **“Plan”** shall have the meaning set forth in Section 1.1.

2.18 **“Plan Administrator”** means the Plan Committee appointed by the Company.

2.19 **“Plan Programs”** means the benefit programs listed on Schedule B and described in the Plan Program Documents. The Plan Programs and Plan Program Documents are subject to change from time to time.

2.20 **“Plan Program Documents”** means the documents described on Schedule B and forming a part of the Plan. The Plan Program Documents for a Plan Program set forth the groups or classifications of Employees who are eligible for benefits under such Plan Program, the terms and conditions relating to eligibility for coverage of such Employees and their Dependents, and the levels and types of benefits payable to or on account of such covered Employees and their covered Dependents.

2.21 **“Plan Year”** shall have the meaning set forth in Section 1.2.

2.22 **“WHCRA”** means the Women’s Health and Cancer Rights Act of 1998, as amended from time to time, and any regulations issued thereunder.

ARTICLE 3

ELIGIBILITY AND PARTICIPATION

3.1 **Employee Eligibility.** Each Employee and his or her eligible Dependents will be covered, and will be eligible for the benefits provided by the Plan, solely in accordance with the terms of the Plan Program Document(s) applicable to the group or classification of Employees of which such Employee is a member.

3.2 **Participation.** Each Eligible Employee and his or her Dependents who met the requirements to participate in the Plan as of the Effective Date shall be a Participant in the Plan on such date. Each other Eligible Employee shall be eligible to participate in the Plan on the date he or she satisfies Section 3.1 and submits such enrollment forms as may be required by the Plan Administrator. A Participant’s enrollment form shall include the Participant’s authorization to reduce his or her cash compensation for any Plan Year (or the relevant portion of a Plan Year) by such amount as may be required by the Plan Administrator.

3.3 **Benefits.** Benefits provided hereunder shall be limited to those benefits described under the terms of the Plan Program Document(s), as such document(s) may be amended from time to time, applicable to the group or classification of Employees of which the Participant is a member. Any termination or cessation of a Participant’s rights or coverage under a Plan Program Document(s) shall be considered a termination or cessation of those same rights under the Plan.

3.4 **Termination of Participation.** Except as otherwise provided in a Plan Program Document, participation under a Plan Program Document will terminate when the Plan terminates, when the Participant no longer qualifies as an Eligible Employee or for any other reason set forth in the applicable Plan Program Document.

3.5 **Leaves of Absence.** The following rules shall apply to an approved leave of absence under the Plan:

(a) **Family and Medical Leave.** A Participant who is on an approved leave of absence under the FMLA may continue participation in the Plan as follows:

(i) *Health Benefits.* A Participant who is on an approved leave under the FMLA shall, to the extent required by the FMLA and permitted by the applicable Plan Program Document, continue his or her health benefits on the same terms and conditions as if the Participant were still an active Employee. The Participant shall continue to pay his or her share of the premium for such coverage on a pre-tax basis to the extent the Participant receives compensation from the Employer during the leave, including payment for unused sick days or vacation pay, or on an after-tax basis if the leave is unpaid or if the Participant has elected to pay premiums on an after-tax basis. Additionally, if the leave will be unpaid and the Participant had been paying premiums on a pre-tax basis, the Participant may make a special election to pre-pay the premiums for such coverage, for the portion of the leave that falls in the current Plan Year, on a pre-tax basis under the Plan, provided such election is made before the compensation used to pre-pay the premiums is paid or made available. The Plan Administrator may also choose to make such other arrangements for payment of premiums with the Participant as may be permitted under the Code or related regulations, provided such arrangements are offered and administered on a uniform and nondiscriminatory basis.

This FMLA continuation of coverage will continue until the first to occur of the Employee's return to active employment with the Employer or the end of the FMLA leave. In the event that the Employee does not return to active employment at the end of the FMLA leave period, except as otherwise provided by a Plan Program Document, the Plan coverage will cease and the Employer may, to the extent permitted by law, recover premiums it paid to maintain health coverage for such employee. In such event, COBRA continuation coverage will be made available to the extent required by COBRA.

(ii) *Non-Health Benefits.* A Participant who is on a paid leave of absence that does not affect eligibility under the terms of the Plan or a Plan Program Document may continue to participate in the Plan on the same terms and conditions as if the Participant were still an active Employee, subject to the terms of the applicable Plan Program Document. The Participant shall continue to pay his or her share of the premiums for such coverage on a pre-tax basis, as applicable, to the extent the Participant receives compensation from the Employer during the leave, including payment for unused sick days or vacation pay. If the Participant takes an unpaid leave of absence that affects eligibility under the terms of the Plan or a Plan Program Document, the election change and termination of coverage rules set forth in the applicable Plan Program Document shall apply, to the extent applicable.

(b) **Military Service Leave.** If a Participant is absent from work due to “qualified” military service within the meaning of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (“USERRA”), the Participant may elect to continue participation under the health portions of the Plan commensurate with the type of coverage(s) in effect on the day immediately prior to the start of USERRA leave, in accordance with USERRA. In order to continue these coverages, the Participant must, to the extent provided by a Plan Program Document, pay the contribution(s) specified for similarly situated active Employees for the type of coverage continued by the Participant during the first 30 days of leave. Thereafter, the Participant is required to pay premium(s) in the same amount as required or permitted under COBRA, unless otherwise arranged by the Company or Participating Employer. With regard to non-health benefits, a Participant who is on a leave of absence from work due to “qualified” military service under USERRA shall be entitled to continue such non-health benefits during the absence on the same terms and to the same extent as similarly situated employees on a non-military leave of absence. Upon a Participant’s return to active employment with the Company, the Participant shall be entitled to participate in the Plan Programs in accordance with the requirements of USERRA.

(c) **Other Leaves of Absence.** A Participant may continue participation in a Plan Program for other leaves of absence to the extent provided under the applicable Plan Program Document.

ARTICLE 4

CONTRIBUTIONS

4.1 **Employee Contributions.** As a condition of participation under the Plan, a Participant shall make such contributions in such amounts and at such times specified by the Plan Program Documents and/or the Plan Administrator as shall be applicable to the group or classification of Employees of which such Employee is a member. An Employee’s contributions shall be made:

(a) On a pre-tax basis, pursuant to an election under the Oaktree Capital Management, L.P. Section 125 Pre-Tax Salary Reduction Health Care Reimbursement Plan;

(b) On an after-tax basis, in accordance with such rules as may be specified by the Company and applicable to the Employee’s classification and Employer; or

(c) In the case of a former Employee, or an Employee on approved unpaid leave, in such manner as the Company shall specify.

4.2 **Employer Contributions.** For each Plan Year, the Employer shall make such contributions under the Plan in such amounts and at such times as the Company shall determine are appropriate.

4.3 **Funding of Benefits.** Benefits payable under the Plan shall be payable from the general assets of the Company or through the purchase of insurance contracts, as applicable. However, the Company does not in any way guarantee the payment of any benefit under the Plan, and no person shall have any right, title or interest in any contributions made under the

Plan. Unless required by applicable law, no trust fund or other funding vehicle shall be established to provide benefits under the Plan and no segregation of assets to provide such benefits will be made by the Company. The Company shall have the right to alter, modify or terminate any funding method in existence as of the effective date of the Plan.

4.4 **Payments To and From Plan.** If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the insurance carrier. Neither the Company nor any Employer shall have any responsibility to pay such benefit.

ARTICLE 5

PLAN ADMINISTRATION

5.1 **Plan Administrator.** The Plan Administrator shall have control of the day-to-day administration of the Plan. However, the Plan Administrator may designate other organizations or persons (who also may be employed by the Company) to carry out specific duties of the Plan Administrator, including but not limited to administration and management duties; claims processing and review; recordkeeping; and preparation of reports and other documents required to be filed with a government agency or distributed to Participants and beneficiaries. Where the Plan Program Document allocates responsibility for deciding claims and claims appeals to the insurer, the insurer shall be the “named fiduciary” and shall be the appropriate agent for service of legal process in connection with claims for benefits under that Plan Program Document.

5.2 **Determination by Plan Administrator Binding.** The Plan Administrator or, where such responsibility has been properly delegated to others, its delegates or insurers, shall have complete discretionary authority to determine the standard of proof required in any case, to determine eligibility for Plan and Plan Program benefits, to apply, construe and interpret the terms of the Plan and Plan Program Documents, to resolve any disputes arising from Plan or Plan Program Document language and to interpret any ambiguous or uncertain terms therein. No benefits shall be paid under the Plan or a Plan Program Document unless the Plan Administrator, its delegate, or any insurer or other third party to whom authority to decide claims has been delegated, has approved them. The decisions of the Plan Administrator, its delegate or any insurer or third party to whom authority to decide claims has been delegated, shall be final and binding. To the extent required by law, the Plan Administrator shall administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated. Notwithstanding any provision of the Plan to the contrary, the Plan Administrator’s authority shall not extend to any benefits matter with respect to which authority to make claims determinations has been delegated to an administrator, insurer or other third party.

5.3 **Information to be Furnished by Participants.** Participants under the Plan must furnish the Plan Administrator or its delegate with such evidence, data or information as the Plan Administrator or its delegate considers necessary or desirable to administer the Plan. A fraudulent misstatement or omission of fact made by a Participant in an enrollment form or otherwise or in a claim for benefits may be used to cancel coverage and/or to deny claims for benefits to the extent permitted by Section 2712 of the Public Health Service Act, as added by the Affordable Care Act.

5.4 **Records.** As a condition of receiving benefits payable under the Plan, a Participant or a beneficiary may be required to provide the Plan Administrator or its delegate or the insurer with such evidence and records of health expenses and/or other relevant losses or expenses incurred by such Participant and in such form as the Plan Administrator or its delegate shall from time to time specify. Additional evidence and records may be requested by the Plan from time to time as reasonably required to determine the Participant's continued eligibility for benefits, as applicable.

5.5 **Action by Company.** Any action required or permitted to be taken by the Company under the Plan shall be by action of the Principal/Chief Financial Officer/Chief Administrative Officer of the Company, the Senior Vice President of Human Resources of the Company, or by such committee, officer or officers as may be designated by the Company with respect to the Plan.

5.6 **Indemnification.** To the extent permitted by law, any director, officer or employee of the Company who is considered as serving in or having served in a fiduciary capacity with respect to the Plan and who has acted in good faith shall be indemnified by the Company against expenses (including the amount of any liability imposed in the form of a money judgment, civil penalty or excise tax, as well as amounts paid in the settlement with approval of the Company) reasonably incurred by him in connection with any action, suit or proceeding to which he may be a party or with which he shall be threatened by reason of his being considered to have served in a fiduciary capacity.

ARTICLE 6

AMENDMENT OR TERMINATION

6.1 **Amendment.** The Company reserves the right to amend the Plan at any time without the consent of any Participant or any other person. All amendments shall be in writing. The Company also reserves the right to amend or eliminate any Plan Program at any time and to add, modify or eliminate benefits provided under any Plan Program, without the consent of any Participant or any other person.

6.2 **Termination.** While the Company expects to continue the Plan, the Company reserves the right to terminate the Plan at any time or to terminate any Plan Program at any time in whole or in part without the consent of any Participant or any other person.

ARTICLE 7

MISCELLANEOUS

7.1 **Additional Employers.** Any affiliate of the Company may, with the consent of the Company, adopt the Plan and designate any one or more existing Plan Programs forming a part of the Plan to be applicable to its Employees or a group of its Employees or establish one or more Plan Programs as applicable to such Employees. An "affiliate" of the Company shall mean a corporation, division or other entity that is a member of a controlled group of businesses within the meaning of Sections 414(b), (c) or (m) of the Code.

7.2 **No Guarantee of Employment.** Nothing contained in the Plan or a Plan Program Document shall be construed as a contract of employment between the Employer and any Participant, or as granting a right to any Participant to be employed by or continue in the employ of the Employer.

7.3 **No Assignment.** Except as may otherwise be specifically provided in the Plan, a Plan Program Document or applicable law, a Participant's rights, interests or benefits under the Plan shall not be subject in any manner to alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the Plan or the Plan Program Documents, and any such attempt shall be void.

7.4 **Notices.** Any notice or document required to be given to or filed with the Plan Administrator shall be considered to be given or filed if delivered to, or mailed by registered mail, postage prepaid, to the Plan Administrator at the Company's principal executive offices. Any notice or document required to be given to or filed with an insurer providing administrative or other services or insurance coverage for the Plan shall be given or filed in accordance with the provisions of the applicable contract issued in connection with the Plan.

7.5 **Applicable Law and Severability.** Except as otherwise preempted by ERISA, all questions pertaining to the construction of the Plan shall be determined in accordance with the laws of the State of California. If any provision of the Plan or any Plan Program Document is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

7.6 **Conflict of Terms.** In the event of a conflict of terms between an insurance company contract and the Plan (including the Plan Program Documents), the insurance company contract shall govern, except that no insurance company contract shall be construed to extend coverage to a person who is not an Employee, as defined in the Plan, or an eligible Dependent of an Employee, as defined in the applicable Plan Program Document or, if not defined therein, as defined under the Plan.

7.7 **Gender and Number.** Where the context admits, words in the masculine gender shall include the feminine and neuter genders, the singular shall include the plural and the plural shall include the singular.

7.8 **Facility of Payment.** When any person entitled to benefits under the Plan is under a legal disability or in the Plan Administrator's opinion is in any way incapacitated so as to be unable to manage his affairs, the Plan Administrator, in its sole discretion, may cause such person's benefits to be paid to such person's legal representative for his benefit, or to be applied for the benefit of such person in any other manner that the Plan Administrator may determine. Such payment shall constitute a full discharge of liability of the Plan for such benefits.

ARTICLE 8

CERTAIN REQUIRED PROVISIONS

8.1 **Applicability.** The following provisions of this Article 8 shall apply to the health benefits under the Plan and to any other Plan Program Document providing group health benefits to which these federal law requirements are applicable (together, the “health Plan Programs”).

8.2 **Newborns’ and Mothers’ Health Protection Act.** The health Plan Programs shall comply, to the extent required by law, with the NMHPA, which requires a plan to provide coverage for a minimum period of time for hospital stays in connection with the birth of a child. To the extent required by the NMHPA, the health Plan Programs shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or a newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, and may not require a provider to obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours for a cesarean section).

8.3 **Mental Health Parity Act.** The health Plan Programs shall comply, to the extent required by law, with the Mental Health Parity Act of 1996, as it may be amended from time to time (“MHPA”) and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

8.4 **WHCRA.** The health Plan Programs shall comply, to the extent required by law, with the WHCRA. To the extent required by the WHCRA, if a Participant is receiving mastectomy-related benefits, coverage must be provided for the following, in consultation with the attending physician:

- (a) All stages of reconstruction of the breast on which the mastectomy was performed;
- (b) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (c) prostheses; and
- (d) treatment of physical complications of the mastectomy, including lymphedemas.

These benefits shall be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable health Plan Program.

8.5 **Pre-existing Conditions.** No “pre-existing condition limitation” shall be imposed under a health Plan Program, except with respect to “excepted benefits” as allowed by HIPAA and the Affordable Care Act. To the extent set forth in Treas. Reg. § 54.9831-1(c)(3), excepted benefits shall mean limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits (a) provided under a separate policy, certificate, or contract of insurance, or (b) for which (i) a Participant has the right to elect not to receive coverage for the benefits, and

(ii) if a Participant elects to receive coverage for the benefits, he or she must pay an additional premium or contribution for such coverage.

8.6 **Special Enrollment.** A health Plan program that is subject to HIPAA shall comply with the special enrollment requirements of Section 701 of ERISA, as amended from time to time.

8.7 **COBRA and Michelle's Law.** A health Plan program shall comply with COBRA and Michelle's Law to the extent that such program is subject to Part 6 of Subtitle B of Title I of ERISA and Section 714 of ERISA, respectively. The following shall apply in administering COBRA continuation coverage as permitted by Treas. Reg. § 54.4980B-7, Q&A-4(b):

(a) The 30-day notice period (during which the Employer is required to notify the Plan Administrator of the occurrence of certain qualifying events, such as the death of the Employee or the termination of employment or reduction of hours of employment of the Employee) shall begin on the date of the loss of coverage rather than on the date of the qualifying event; and

(b) The end of the maximum coverage period shall be measured from the date of the loss of coverage rather than from the date of the qualifying event.

ARTICLE 9

COORDINATION OF BENEFITS AND SUBROGATION

9.1 **Coordination of Benefits.** Benefits otherwise payable under the health Plan Program(s) will be coordinated with benefits payable by another health care benefits plan as provided for in the applicable Plan Program Document.

9.2 **Right to Recovery.** If payment has been made by the Plan in excess of the benefits provided under the terms of the Plan or applicable Plan Program Document(s), the Plan shall have the right to recover such excess from any party receiving the excess payment.

9.3 **Offset.** In the event any payment is made by the Plan to or on behalf of a Participant or beneficiary who is not entitled to such payment, the Plan shall have the right to reduce future payments to such Participant, a covered family member or any beneficiary by the amount of the erroneous payment. This right of offset shall not limit the right of the Plan to recover such overpayments in any other manner.

9.4 **Right to Information.** For the purposes of implementing or determining the applicability of this Article 9 or any provision of similar purpose in another benefit plan, the Plan may, to the extent permitted by law, and without the consent of or notice to any Participant or beneficiary, release to or obtain from any insurance company or other organization or individual any information which the Plan deems to be necessary for such purposes. Any Participant or beneficiary claiming benefits under the Plan shall, as a condition of receiving benefits under the Plan, furnish to the Plan Administrator or its delegate or designee such information as may be necessary to implement this provision.

9.5 **Another Health Benefits Plan, No-Fault Auto Coverage.** To the extent consistent with the terms of the applicable Plan Program Document and any agreement providing for administrative services to the Plan, “another health benefits plan” means any group insurance or any other arrangement for coverage of individuals in a group, whether on an insured or uninsured basis; coverage under any health maintenance organization, managed care arrangement, Medicare or Medicaid (the latter to the extent permitted by law); or no-fault automobile coverage. For purposes of the Plan, to the extent not inconsistent with the terms of the applicable Plan Program Document, in states with compulsory no-fault auto insurance laws, each individual shall be deemed to have full no-fault coverage to the maximum required in that state. Except to the extent otherwise provided under an applicable Plan Program Document, the Plan will coordinate benefits with no-fault coverage as defined in the state of residence, whether or not the individual is in compliance with the law, or whether or not the maximum coverage is actually carried.

9.6 **Subrogation.** Benefits payable to or on behalf of a Participant under the Plan are conditioned on that Participant’s compliance with the subrogation rules, if any, contained in the applicable Plan Program Document(s), and with the following, to the extent not inconsistent with such Plan Program Document(s):

(a) **Conditional benefit payments.** If a Participant has income loss as a result of an injury, illness or condition for which a third party is, or may be, held responsible, the Plan Administrator may make advance payments to, or on behalf of, such Participant, subject to the Plan’s subrogation rights. However, before any such payments will be conditionally made, the Participant (or the Participant’s legal guardian if the Participant is a minor) shall execute an agreement that acknowledges and affirms (i) the conditional nature of the payments and (ii) the Plan’s rights of subrogation, as provided for under Section 9.6(b) below.

(b) **Subrogation.** If a Participant receives any benefits arising out of an injury, illness, condition or other loss for which the Participant (or the Participant’s guardian, estate or beneficiary) has, may have, or may assert any claim or right to recovery against a third party or parties, then any payment or payments under the Plan for such benefits shall be made on the condition and with the understanding that the Plan will be reimbursed. Such reimbursement will be made by the Participant (or the Participant’s legal guardian if the Participant is a minor, or the Participant’s estate or beneficiary) to the extent of, but not exceeding, the total amount payable to or on behalf of the Participant (or the Participant’s guardian, estate or beneficiary) from: (i) any policy or contract from any insurance company or carrier (including the Participant’s insurer) and/or (ii) any third party, plan or fund as a result of a judgment or settlement. The Participant on behalf of himself (or his guardian, estate or beneficiary) acknowledges and agrees that the Plan will be reimbursed in full before any amounts (including attorney fees incurred by the Participant or his guardian, estate or beneficiary) are deducted from the policy, proceeds, judgment or settlement.

The Plan will be subrogated to all claims, demands, actions and right of recovery against any entity including, but not limited to, third parties and insurance companies and carriers (including the Participant’s insurer) to the fullest extent permitted by law in the appropriate jurisdiction. The amount of such subrogation will equal the total amount paid under the Plan arising out of the injury or illness for which the Participant (or the Participant’s guardian, estate

or beneficiary) has, may have or may assert a cause of action. In addition, the Plan will be subrogated for attorney's fees incurred in enforcing its subrogation rights under this Section.

The Participant on behalf of himself (or his guardian, estate or beneficiary) specifically agrees not to do anything to prejudice the Plan's rights to reimbursement or subrogation. In addition, the Participant on behalf of himself (or his guardian, estate or beneficiary) agrees to cooperate fully with the Plan Administrator in asserting and protecting the Plan's subrogation rights. The Participant on behalf of himself (or his guardian, estate or beneficiary) agrees to execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect his Plan's subrogation rights.

Finally, the Participant on behalf of himself (or his guardian, estate or beneficiary) specifically agrees to notify the Plan Administrator, in writing, whenever benefits are paid under the Plan for an income loss that arises out of any injury, illness, condition or loss that provides or may provide the Plan subrogation rights under this Section.

Failure to comply with the requirements of this Section by the Participant (or his guardian, estate or beneficiary) may, at the Plan Administrator's discretion, result in a forfeiture of benefits under the Plan.

ARTICLE 10

HIPAA MEDICAL PRIVACY AND SECURITY PROVISIONS

10.1 **Definitions.** The following definitions shall apply solely for purposes of this Article 10 of the Plan. Unless otherwise defined herein, capitalized terms used in this Article shall have the meanings assigned to them by 45 C.F.R. Sections 160.103 and 164.304.

(a) **"Electronic Media"** has the same meaning given to that term under 45 C.F.R. Section 160.103 and shall include memory devices in computers (hard drives) and any removable or transportable digital memory medium such as magnetic tape or disk, optical disk or digital memory card; or any transmission media used to exchange information already in electronic storage media, including the Internet, an extranet, leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media. Electronic media shall not include paper, fax and voice (via telephone) transmissions.

(b) **"Electronic Protected Health Information"** means Protected Health Information that is transmitted by or maintained in Electronic Media.

(c) **"Employer"** means the Plan Sponsor.

(d) **"Health Information"** means any information, whether oral or recorded in any form or manner, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university or health care clearinghouse that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual.

(e) **“Individually Identifiable Health Information”** means Health Information, including demographic information, that is created or received by a health care provider, health plan, employer or health care clearinghouse that identifies the individual involved or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(f) **“Plan”** means the self-insured health plan component of the Plan.

(g) **“Plan Administrative Functions”** means, but is not limited to, monitoring or auditing the functioning of the Plan, claims processing, utilization review, business planning, development and management, customer service, risk adjustment, billing, collection activities, review of health care services, determinations of eligibility or coverage and resolution of internal grievances and activities pursuant to the sale, transfer, merger, termination, etc. of all or part of the Plan.

(h) **“Plan Sponsor”** means the Company.

(i) **“Privacy Regulations”** means the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and E, as they may be amended from time to time.

(j) **“Protected Health Information”** or “PHI” has the same meaning as given this term in 45 C.F.R. 164.501 and shall mean individually identifiable health information maintained and transmitted in any form or medium, including, without limitation, all information (including demographic, medical and financial information), data, documentation and materials created or received by a health care provider, health plan, employer or health care clearinghouse, and that relates to (i) the past, present or future physical or mental health or condition of an individual; (ii) the provision of health care to an individual; or (iii) the past, present or future payment for the provision of health care to an individual, and that identifies or could reasonably be used to identify an individual. For purposes of this Agreement, Protected Health Information does not include health information that has been de-identified in accordance with the standards for de-identification set forth in the Privacy Regulations; employment records held by the Employer in its role as an employer; or education and other records exempted from the Privacy Regulations under 45 C.F.R. 164.501.

(k) **“Security Incident”** means any attempted or successful (i) unauthorized Access, Use, Disclosure, modification or destruction of the Plan’s Electronic PHI or (ii) unauthorized interference with system operations in the Plan’s Information System of which the Plan Sponsor becomes aware.

(l) **“Security Regulations”** means the Standards for the Security of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, as amended from time to time.

(m) **“Summary Health Information”** means information that summarizes the claims history, claims expenses or types of claims by individuals for whom the Company provides benefits under the Plan, and from which the following information has been removed:

- (i) names;
- (ii) geographic information (all geographic divisions smaller than a state), except that the geographic information described in Section 164.514(b)(2)(i)(B) of the Privacy Regulations need only be aggregated to the level of a five-digit zip code;
- (iii) all elements of dates (except year) relating to the individual(s) involved, including birth date, admission date, discharge date, date of death; all ages over 89 and elements of dates indicative of such age (except that such ages and elements may be aggregated into a single category of age 90 or older);
- (iv) other identifying numbers, such as Social Security, telephone, Fax or medical record numbers, health Plan beneficiary numbers, account numbers, license plate and similar numbers, URLs, facial photos or biometric identifiers (e.g., fingerprints), electronic mail addresses, VIN numbers, serial numbers and certificate/license numbers or IP address numbers; and
- (v) any other unique identifying number, characteristic or code, provided the Plan does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

10.2 **Permitted and Required Uses and Disclosures.** The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted and required by the Privacy Regulations and related guidance. Specifically, the Plan will use and disclose PHI under the following circumstances only:

- (a) **Permitted uses and disclosures:**
 - (i) to the individual or the individual's personal representative;
 - (ii) for purposes related to health care treatment, payment for health care or health care operations, as permitted by Section 164.506 of the Privacy Regulations;
 - (iii) incident to a use or disclosure otherwise permitted or required under this Section 10.2 or Section 164.502 of the Privacy Regulations, provided the Plan has complied with the applicable requirements of the Privacy Regulations with respect to such use or disclosure;
 - (iv) in compliance with an authorization from the individual or a personal representative to disclose PHI that complies with Section 164.508 of the Privacy Regulations; and
 - (v) to the extent of and for the purposes permitted under Sections 164.510 (including emergency notification of a family member); 164.512 (including certain disclosures for judicial and administrative proceedings, certain law enforcement purposes, certain disclosures about deceased persons and to avert a serious threat to

health or safety); and 164.514(e) (PHI contained in a “limited data set”) of the Privacy Regulations.

(b) **Required uses and disclosures:**

(i) to the individual or a personal representative who exercises his or her right to access their individual PHI in accordance with Section 164.524 of the Privacy Regulations and the rules requiring a covered entity to provide an accounting of PHI disclosures under Section 164.528 of the Privacy Regulations; and

(ii) to the U.S. Department of Health and Human Services when requested in order to determine whether a covered entity is complying with the Privacy Regulations.

(c) **Disclosure of Summary Health Information and Enrollment and Disenrollment Information.** In addition to the disclosures permitted under Section 10.2(a) above, the Plan may disclose Summary Health Information to the Company if the Company requests such information for the purpose of obtaining premium bids for providing health insurance under the Plan, or for modifying, amending or terminating the Plan. Moreover, the Plan may disclose to the Company information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(d) **Disclosure of Genetic Information.** Notwithstanding anything to the contrary herein, the Plan may not use or disclose PHI that is genetic information for underwriting purposes. To the extent set forth in 45 CFR § 164.502(a)(5)(i), underwriting purposes shall include (i) rules for or determination of benefits under the Plan, (ii) computing premium or contribution amounts under the Plan, (iii) applying pre-existing condition exclusions under the Plan, and (iv) other activities related to creating, renewing or replacing a contract for health benefits. Underwriting purposes does not include determining medical appropriateness when an individual seeks a benefit under the Plan.

10.3 **Certification.** The Plan shall disclose PHI to the Company in accordance with this Article only upon receipt of a written certification from the Company that (a) the Plan documents have been amended by this Article to incorporate the provisions set forth in Section 10.4 below, and (b) the Company agrees to comply with said provisions.

10.4 **Company’s Agreement Regarding PHI.** The Company agrees to do the following:

(a) not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;

(b) ensure that any of its agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions to which the Company is subject;

(c) not use or disclose PHI for employment-related actions or decisions or in connection with any of its other benefits or employee benefit plans;

(d) report to the Plan any use or disclosure of PHI of which the Company becomes aware that is inconsistent with Section 10.2 of this Article 10;

(e) make PHI available to individuals who exercise their right to gain access to their individual PHI in accordance with Section 164.524 of the Privacy Regulations;

(f) make PHI available pursuant to a valid request for an accounting of an individual's PHI disclosures in accordance with Section 164.528 of the Privacy Regulations;

(g) make PHI available to individuals for purposes of allowing them to request an amendment to the information, and to incorporate any such amendment to the extent required under Section 164.526 of the Privacy Regulations;

(h) make its internal practices, books and records relating to the use and disclosure of PHI available to the U.S. Department of Health and Human Services when requested for purposes of determining whether the Plan is complying with the privacy laws and regulations;

(i) if feasible, when no longer needed for the purpose disclosed, return or destroy all PHI from the Plan that the Company maintains in any form, retaining no copies; or, if not feasible, then to limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) ensure that there is adequate separation between the Plan and the Company, as described in Section 10.6.

10.5 **Company's Agreement Regarding Electronic PHI.** The Company agrees to do the following:

(a) implement Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

(b) ensure that the adequate separation required by 45 C.F.R. Section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(c) ensure that any agent to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) to report to the Plan any Security Incident of which it becomes aware.

10.6 **Adequate Separation between Plan and Employer.**

(a) **Designated Personnel.** In accordance with Section 164.504(f)(2)(iii) of the Privacy Regulations, the following titles or classes of employees are to be given access to Plan PHI:

Managing Principal

Principal, Chief Financial and Administrative Officer
General Counsel and designated members of the Legal department
Privacy and Security Officer
Human Resources department staff members and designated liaisons
Designated staff members of the Compliance department
Designated staff members of Infrastructure Services, including Information Technology, that support Human Resources
Staff members of the Internal Audit group (including consultants) that support Human Resources
Staff members of the Corporate Finance, Accounts Payable and Accounting departments and designated staff members that support these departments or related functions
Designated Administrative Assistants supporting any of the above-listed individuals

(b) **Restricted use of PHI.** Access to and use of PHI by the individuals described above shall be restricted to the Plan Administrative Functions that the Company performs for the Plan.

(c) **Noncompliance.** Any individual listed in Section 10.6(a) above who fails to comply with this Article 10 shall be subject to the following disciplinary procedure:

Sanctions shall be imposed by the Plan Sponsor taking into account the severity of the violation and whether it constitutes a repeat offense (or leads to liability for the Plan Sponsor). Sanctions may include oral or written warnings, time off without pay and termination for successive or severe violations of this Article or any other HIPAA privacy or security policy or procedure adopted by the Plan Sponsor.

ARTICLE 11

BENEFIT CLAIM PROCEDURE

11.1 **Claims for Benefits.** Benefits under the Plan shall be administered in accordance with the claims procedure set forth in the applicable Plan Program Document. No denial of such benefits with respect to a claimant shall be deemed to be final for purposes of commencing legal proceedings until the claimant has exhausted the claims procedures provided under the Plan Program Document. Any such claims procedures shall comply, to the extent applicable, with the requirements of Section 2719 of the Public Health Service Act, as added by the Affordable Care Act, and any implementing regulations and guidance issued thereunder. Notwithstanding any provision in a Plan Program Document to the contrary, the Plan Administrator's authority shall not extend to any matter with respect to which authority to make final claims determinations has been delegated to an administrator, insurer or other third party.

11.2 **Notice and Proof of Claim.** Unless another such limitations period is provided in an applicable Plan Program Document, written proof covering the occurrence, character and extent of the loss for which claim is made must be filed with the Plan Administrator or its delegate within 12 months after the date the expense is incurred or the event occurs for which the

claim is made. In addition, except to the extent a shorter period applies under the applicable Plan Program Document or under any applicable statute of limitations, no legal action may be brought to obtain benefits under the Plan any later than 3 years after the expense is incurred or event occurs for which the action is brought.

11.3 **Delegated Authority.** Notwithstanding any provisions of a Plan Program Document to the contrary, the Plan Administrator's authority under this Article 11 shall not extend to any matter with respect to which authority to make final claims determinations has been delegated to an administrator, insurer or other third party.

IN WITNESS WHEREOF, the Company has caused the above and foregoing Plan to be executed by its duly authorized representative(s) this ____ day of December, 2013.

OAKTREE CAPITAL MANAGEMENT, L.P.

By: _____
Suzette Ramirez-Carr
Managing Director

SCHEDULE A

PARTICIPATING EMPLOYERS

Oaktree Capital Management, L.P.
Oaktree Capital Group Holdings, GP, LLC
Oaktree Capital Management (UK) LLP

SCHEDULE B

PLAN PROGRAM DOCUMENTS

Employees eligible and benefits payable are described in the following documents and agreements, as updated from time to time, which constitute a part of the Plan.

1. Oaktree Capital Management, L.P. booklet describing medical, prescription drug and dental expense coverage, including all amendments thereto.
2. Oaktree Capital Management, L.P. Flexible Benefits Plan.
3. Oaktree Capital Management, L.P. Health and Welfare Plan Qualified Medical Child Support Order (QMCSO) Procedure.
4. Group term life, accidental death and dismemberment and long-term disability policy(ies) and certificates of coverage from Sun Life Assurance Company of Canada.
5. New York state disability insurance policy from Sun Life Insurance and Annuity Company of New York (for employees located in New York).
6. Vision benefits provided under the policy issued by VSP (Vision Service Plan).
7. Medical information services provided under the Best Doctors Associated Group Health Agreement.
8. Health screening and wellness services provided under the Services Agreement with Preventure, Inc.
9. Voluntary long term care insurance from UNUM.
10. Medical, prescription drug and dental benefits for U.S.-based employees on temporary assignment outside the United States and U.S. Nationals and such employees' eligible dependents provided by Delaware American Life Insurance Company pursuant to the Delaware American Expatriate Group Insurance Trust and under the group insurance policy issued to Oaktree Capital Management, L.P. and related certificate of insurance.

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NGEDOCs: 2138078.8



OAKTREE

401(k) Savings Plan

Summary Plan Description with Attachments

OAKTREE CAPITAL MANAGEMENT, L.P. 401(K) SAVINGS PLAN

SUMMARY PLAN DESCRIPTION

Effective September 1, 2013

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OAKTREE CAPITAL MANAGEMENT, L.P. 401(K) SAVINGS PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION TO YOUR PLAN

What kind of Plan is this?

Oaktree Capital Management, L.P. 401(k) Savings Plan ("Plan") has been adopted to provide you with the opportunity to save for retirement on a tax-advantaged basis. This Plan is a type of qualified retirement plan commonly referred to as a 401(k) Plan. As a participant in the Plan, you may elect to contribute a portion of your compensation to the Plan.

What information does this Summary provide?

This Summary Plan Description ("SPD") contains information regarding when you may become eligible to participate in the Plan, your Plan benefits, your distribution options, and many other features of the Plan. You should take the time to read this SPD to get a better understanding of your rights and obligations under the Plan.

In this summary, your Employer has addressed the most common questions you may have regarding the Plan. If this SPD does not answer all of your questions, please contact the Administrator or other plan representative. The Administrator is responsible for responding to questions and making determinations related to the administration, interpretation, and application of the Plan. The name and address of the Administrator can be found at the end of this SPD in the Article entitled "General Information About the Plan."

This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language and is designed to comply with applicable legal requirements. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

The Plan and your rights under the Plan are subject to federal laws, such as the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code, as well as some state laws. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or Department of Labor (DOL). Your Employer may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, your Employer will notify you.

Types of Contributions. The following types of contributions may be made under this plan:

- employee salary deferrals including Roth 401(k) deferrals
- employee rollover contributions
- employer matching contributions
- employer profit sharing contributions

ARTICLE I PARTICIPATION IN THE PLAN

How do I participate in the Plan?

Provided you are not an Excluded Employee, you may begin participating under the Plan once you have satisfied the eligibility requirements and reached your "Entry Date." The following describes the eligibility requirements and Entry Dates that apply. You should contact the Administrator if you have questions about the timing of your Plan participation.

Salary Deferrals

Excluded Employees. If you are a member of a class of employees identified below, you are an Excluded Employee and you are not entitled to participate in the Plan for purposes of salary deferrals and rollover contributions. The Excluded Employees are:

- union employees whose employment is governed by a collective bargaining agreement under which retirement benefits were the subject of good faith bargaining
- certain nonresident aliens who have no earned income from sources within the United States
- leased employees

- The following groups are excluded: For nonelective profit sharing, employees with ID number 10599. Employees of Oaktree Capital Mgmt (UK) LLP shall be excluded from participating in all contributions, except for an employee who was a participant in the Plan prior to becoming an employee of Oaktree Capital Mgmt (UK) LLP.

Eligibility Conditions. You will be eligible to participate for purposes of salary deferrals on your date of hire. However, you will actually enter the Plan once you reach the Entry Date as described below.

Entry Date. For purposes of salary deferrals, your Entry Date will be the first day of the month coinciding with or next following the date you satisfy the eligibility requirements.

Matching Contributions

Excluded Employees. If you are a member of a class of employees identified below, you are an Excluded Employee and you are not entitled to participate in the Plan for purposes of matching contributions. The Excluded Employees are:

- union employees whose employment is governed by a collective bargaining agreement under which retirement benefits were the subject of good faith bargaining
- certain nonresident aliens who have no earned income from sources within the United States
- leased employees
- The following groups are excluded: For nonelective profit sharing, employees with ID number 10599. Employees of Oaktree Capital Mgmt (UK) LLP shall be excluded from participating in all contributions, except for an employee who was a participant in the Plan prior to becoming an employee of Oaktree Capital Mgmt (UK) LLP.

Eligibility Conditions. You will be eligible to participate for purposes of matching contributions on your date of hire. However, you will actually enter the Plan once you reach the Entry Date as described below.

Entry Date. For purposes of matching contributions, your Entry Date will be the first day of the month coinciding with or next following the date you satisfy the eligibility requirements.

Profit Sharing Contributions

Excluded Employees. If you are a member of a class of employees identified below, you are an Excluded Employee and you are not entitled to participate in the Plan for purposes of profit sharing contributions. The Excluded Employees are:

- union employees whose employment is governed by a collective bargaining agreement under which retirement benefits were the subject of good faith bargaining
- certain nonresident aliens who have no earned income from sources within the United States
- leased employees
- The following groups are excluded: For nonelective profit sharing, employees with ID number 10599. Employees of Oaktree Capital Mgmt (UK) LLP shall be excluded from participating in all contributions, except for an employee who was a participant in the Plan prior to becoming an employee of Oaktree Capital Mgmt (UK) LLP.

Eligibility Conditions. You will be eligible to participate for purposes of profit sharing contributions when you have satisfied the following eligibility condition(s). However, you will actually enter the Plan once you reach the Entry Date as described below.

- completion of one (1) Year of Service.

The service requirement for profit sharing contributions is waived for all non-officer employees earning \$125,000 or less during the plan year employed on 12/31/2011. Such Eligible Employees shall enter the Plan on this date.

Entry Date. For purposes of profit sharing contributions, your Entry Date will be the first day of the Plan Year during which you satisfy the eligibility requirements.

How is my service determined for purposes of Plan eligibility?

Year of Service. You will be credited with a Year of Service at the end of the twelve month period beginning on your date of hire if you have been credited with at least 1,000 Hours of Service during such period. If you have not been credited with 1,000 Hours of Service by the end of such period, you will have completed a Year of Service at the end of any following Plan Year during which you were credited with 1,000 Hours of Service.

Hour of Service - Employees for whom hourly records are kept. You will be credited with your actual Hours of Service for:

- (a) each hour for which you are directly or indirectly compensated by the Employer for the performance of duties during the Plan Year;
- (b) each hour for which you are directly or indirectly compensated by the Employer for reasons other than the performance of duties (such as vacation, holidays, sickness, disability, lay-off, military duty, jury duty or leave of absence during the Plan Year); and
- (c) each hour for back pay awarded or agreed to by the Employer.

You will not be credited for the same Hours of Service both under (a) or (b), as the case may be, and under (c).

Hour of Service - Employees for whom hourly records are not kept. The Plan does not credit you with your actual Hours of Service. Instead the Plan uses an "equivalency" method. Under this method you will be credited with 45 Hours of Service for each week during the year in which you would otherwise be credited with at least one Hour of Service.

What service is counted for purposes of Plan eligibility?

Service with the Employer. In determining whether you satisfy the minimum service requirements to participate under the Plan, all service you perform for the Employer will generally be counted. However, there are some exceptions to this general rule.

Break in Service rules. If you terminate employment and are rehired, you may lose credit for prior service under the Plan's Break in Service rules.

For eligibility purposes, you will have a Break in Service if you have not completed more than one-half the Hours of Service needed for a Year of Service during the computation period used to determine whether you have a Year of Service. However, if you are absent from work for certain leaves of absence such as a maternity or paternity leave, you may be credited with enough Hours of Service to prevent a Break in Service.

Military Service. If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with the Employer. If you may be affected by this law, ask the Administrator for further details.

What happens if I'm a participant, terminate employment and then I'm rehired?

If you are no longer a participant because you terminated employment, and you are rehired, then you will be able to participate in the Plan on your date of rehire provided your prior service had not been disregarded under the Break in Service rules and you are otherwise eligible to participate in the Plan.

ARTICLE II EMPLOYEE CONTRIBUTIONS

What are salary deferrals and how do I contribute them to the Plan?

Salary Deferrals. As a participant under the Plan, you may elect to reduce your compensation by a specific percentage or dollar amount and have that amount contributed to the Plan as a salary deferral. Effective 02/16/2006, there are two types of salary deferrals: Pre-Tax 401(k) deferrals and Roth 401(k) deferrals. For purposes of this SPD, "salary deferrals" generally means both Pre-Tax 401(k) deferrals and Roth 401(k) deferrals. Regardless of the type of deferral you make, the amount you defer is counted as compensation for purposes of Social Security taxes.

Pre-Tax 401(k) Deferrals. If you elect to make Pre-Tax 401(k) deferrals, then your taxable income is reduced by the deferral contributions so you pay less in federal income taxes. Later, when the Plan distributes the deferrals and earnings, you will pay the taxes on those deferrals and the earnings. Therefore, with a Regular 401(k) deferral, federal income taxes on the deferral contributions and on the earnings are only postponed. Eventually, you will have to pay taxes on these amounts.

Roth 401(k) Deferrals. If you elect to make Roth 401(k) deferrals, the deferrals are subject to federal income taxes in the year of deferral. However, the deferrals and, in most cases, the earnings on the deferrals are not subject to federal income taxes when distributed to you. In order for the earnings to be tax free, you must meet certain conditions. See "What are my tax consequences when I receive a distribution from the Plan?" below.

Deferral procedure. The amount you elect to defer will be deducted from your pay in accordance with a procedure established by the Administrator. The procedure will require that you enter into a salary deferral agreement after you satisfy the Plan's eligibility requirements. You may elect to defer a portion of your salary as of your Entry Date or on the first day of each month. Such election will become effective as soon as administratively feasible after it is received by the Administrator. Your election will remain in effect until you modify or terminate it.

Deferral modifications. You are permitted to revoke your salary deferral election at any time during the Plan Year. You may make any other modification on the first day of each month or in accordance with any other procedure that your Employer provides. Any modification will become effective as soon as administratively feasible after it is received by the Administrator.

Deferral Limit. As a participant, you may elect to defer up to 75% of your compensation each year instead of receiving that amount in cash. In addition, you may separately elect to defer up to 100% of any bonuses paid to you during the year. Your total deferrals in any taxable year may not exceed a dollar limit which is set by law. The limit for 2013 is \$17,500. After 2013, the dollar limit may increase for cost-of-living adjustments. See the paragraph below on Annual dollar limit.

Catch-up contributions. Effective 01/01/2002, if you are at least age 50 or will attain age 50 before the end of a calendar year, then you may elect to defer additional amounts (called "catch-up contributions") to the Plan as of the January 1st of that year. The additional amounts may be deferred regardless of any other limitations on the amount that you may defer to the Plan, except for the percentage deferral limit in the paragraph above. The maximum "catch-up contribution" that you can make in 2013 is \$5,500. After 2013, the maximum may increase for cost-of-living adjustments.

Annual dollar limit. You should also be aware that each separately stated annual dollar limit on the amount you may defer (the annual deferral limit and the "catch-up contribution" limit) is a separate aggregate limit that applies to all such similar salary deferral amounts and "catch-up contributions" you may make under this Plan and any other cash or deferred arrangements (including tax-sheltered 403(b) annuity contracts, simplified employee pensions or other 401(k) plans) in which you may be participating. Generally, if an annual dollar limit is exceeded, then the excess must be returned to you in order to avoid adverse tax consequences. For this reason, it is desirable to request in writing that any such excess salary deferral amounts and "catch-up contributions" be returned to you.

If you are in more than one plan, you must decide which plan or arrangement you would like to return the excess. If you decide that the excess should be distributed from this Plan, you must communicate this in writing to the Administrator no later than the March 1st following the close of the calendar year in which such excess deferrals were made. However, if the entire dollar limit is exceeded in this Plan or any other plan your Employer maintains, then you will be deemed to have notified the Administrator of the excess. The Administrator will then return the excess deferrals and any earnings to you by April 15th.

Allocation of deferrals. The Administrator will allocate the amount you elect to defer to an account maintained on your behalf. You will always be 100% vested in this account (see the Article in this SPD entitled "Vesting"). This means that you will always be entitled to all amounts that you defer. This money will, however, be affected by any investment gains or losses. If there is an investment gain, then the balance in your account will increase. If there is an investment loss, then the balance in your account will decrease.

Distribution of deferrals. The rules regarding distributions of amounts attributable to your salary deferrals are explained later in this SPD. However, if you are a highly compensated employee (generally more than 5% owners or individuals receiving wages in excess of certain amounts established by law), a distribution of amounts attributable to your salary deferrals or certain excess contributions may be required to comply with the law. The Administrator will notify you when a distribution is required.

What are rollover contributions?

Rollover contributions. At the discretion of the Administrator, if you are a Participant who is currently employed or an Eligible Employee, you may be permitted to deposit into the Plan distributions you have received from other retirement plans and certain IRAs. Such a deposit is called a "rollover" and may result in tax savings to you. You may ask the Administrator or Trustee of the other plan or IRA to directly transfer (a "direct rollover") to this Plan all or a portion of any amount that you are entitled to receive as a distribution from such plan. Alternatively, you may elect to deposit any amount eligible to be rolled over within 60 days of your receipt of the distribution. You should consult qualified counsel to determine if a rollover is in your best interest.

Rollover account. Your rollover will be accounted for in a "rollover account." You will always be 100% vested in your "rollover account" (see the Article in this SPD entitled "Vesting"). This means that you will always be entitled to all amounts in your rollover account. Rollover contributions will be affected by any investment gains or losses. In addition, any Roth 401(k) Deferrals that are accepted as rollovers in this Plan will be accounted for separately.

Withdrawal of rollover contributions. You may withdraw the amounts in your "rollover account" at any time.

ARTICLE III EMPLOYER CONTRIBUTIONS

In addition to any deferrals you elect to make, your Employer may make additional contributions to the Plan. This Article describes Employer contributions that may be made to the Plan and how your share of the contribution is determined.

What is the Employer matching contribution and how is it allocated?

Matching Contribution. Your Employer may make a discretionary matching contribution equal to a uniform percentage of your salary deferrals. Each year, your Employer will determine the amount of the discretionary percentage.

Limit on matching percentage. In applying this matching percentage, however, your Employer has the option to disregard salary deferrals made each year that exceed a certain dollar amount or a certain percentage of your compensation for such period. The Plan Administrator will inform you of this limit.

Allocation conditions. You will always share in the matching contribution regardless of the amount of service you complete during the Plan Year.

What is the Employer profit sharing contribution and how is it allocated?

Profit sharing contribution. Each year, your Employer may make a discretionary profit sharing contribution to the Plan. Your share of any contribution is determined below.

Allocation conditions. In order to share in the profit sharing contribution for a Plan Year, you must satisfy the following conditions:

- If you are employed on the last day of the Plan Year, you will share if you completed a Period of Service during the Plan Year.
- If you terminate employment (not employed on the last day of the Plan Year), you will not receive a profit sharing contribution regardless of the amount of service you complete during the Plan Year.

Your share of the contribution. The profit sharing contribution will be "allocated" or divided among participants eligible to share in the contribution for the Plan Year.

Your share of the profit sharing contribution will depend on how much compensation you received during the year as well as the classification to which you are assigned (see below). Your Employer may contribute a different amount on behalf of each classification. The amount contributed on behalf of your classification will be allocated to you proportionately based on your compensation compared to the total compensation of all participants in your classification. You will be categorized into one of the following classifications:

- Classification A will consist of: Principals (any age) + Managing Directors (age 38 and above) + Senior Vice Presidents (age 38 and above) determined as of the last day of the Plan year
- Classification B will consist of: Managing Directors (under age 38) + Senior Vice Presidents (under age 38) determined as of the last day of the Plan year
- Classification C will consist of: All other Employees not in Classification A or B who are Highly Compensated Employees
- Classification D will consist of: All other Employees not in Classification A or B who are Non-highly Compensated Employees
- Additional classifications will consist of: Classification E shall consist of: Employee No. 10227 who shall be in Classification E, notwithstanding that he or she would otherwise be included in one of the Classifications A through D as described above.

How is my service determined for allocation purposes?

Period of Service. You will be credited with a Period of Service for a Plan Year if you were employed at any time during the Plan Year.

**ARTICLE IV
COMPENSATION AND ACCOUNT BALANCE**

What compensation is used to determine my Plan benefits?

Definition of compensation. For the purposes of the Plan, compensation has a special meaning. Compensation is generally defined as your total compensation that is subject to income tax withholding and paid to you by your Employer during the Plan Year. If you are a self-employed individual, your compensation will be equal to your earned income. The following describes the adjustments to compensation that may apply for the different types of contributions provided under the Plan.

All Contributions

Adjustments to compensation. The following adjustments to compensation will be made:

- salary deferrals to this Plan and to any other plan or arrangement (such as a cafeteria plan) will be included.

Salary Deferrals

Adjustments to compensation. The following adjustments to compensation will be made for purposes of salary deferrals:

- compensation paid after you terminate is generally excluded for Plan purposes. However, the following amounts will be included in compensation even though they are paid after you terminate employment, provided these amounts would otherwise have been considered compensation as described above and provided they are paid within 2 1/2 months after you terminate employment, or if later, the last day of the Plan Year in which you terminate employment:
 - compensation for services performed during your regular working hours, or for services outside your regular working hours (such as overtime or shift differential) or other similar payments that would have been made to you had you continued employment
 - compensation paid for unused accrued bona fide sick, vacation or other leave, if such amounts would have been included in compensation if paid prior to your termination of employment and you would have been able to use the leave if employment had continued
 - nonqualified unfunded deferred compensation if the payment is includible in gross income and would have been paid to you had you continued employment

Matching Contributions

Adjustments to compensation. The following adjustments to compensation will be made for purposes of matching contributions:

- compensation paid after you terminate is generally excluded for Plan purposes. However, the following amounts will be included in compensation even though they are paid after you terminate employment, provided these amounts would otherwise have been considered compensation as described above and provided they are paid within 2 1/2 months after you terminate employment, or if later, the last day of the Plan Year in which you terminate employment:
 - compensation for services performed during your regular working hours, or for services outside your regular working hours (such as overtime or shift differential) or other similar payments that would have been made to you had you continued employment
 - compensation paid for unused accrued bona fide sick, vacation or other leave, if such amounts would have been included in compensation if paid prior to your termination of employment and you would have been able to use the leave if employment had continued
 - nonqualified unfunded deferred compensation if the payment is includible in gross income and would have been paid to you had you continued employment

Profit Sharing Contributions

Adjustments to compensation. The following adjustments to compensation will be made for purposes of profit sharing contributions:

- compensation paid after you terminate is generally excluded for Plan purposes. However, the following amounts will be included in compensation even though they are paid after you terminate employment, provided these amounts would otherwise have been considered compensation as described above and provided they are paid within 2 1/2 months after you terminate employment, or if later, the last day of the Plan Year in which you terminate employment:
 - compensation for services performed during your regular working hours, or for services outside your regular working hours (such as overtime or shift differential) or other similar payments that would have been made to you had you continued employment
 - compensation paid for unused accrued bona fide sick, vacation or other leave, if such amounts would have been included in compensation if paid prior to your termination of employment and you would have been able to use the leave if employment had continued
 - nonqualified unfunded deferred compensation if the payment is includible in gross income and would have been paid to you had you continued employment

Is there a limit on the amount of compensation which can be considered?

The Plan, by law, cannot recognize annual compensation in excess of a certain dollar limit. The limit for the Plan Year beginning in 2013 is \$255,000. After 2013, the dollar limit may increase for cost-of-living adjustments.

Is there a limit on how much can be contributed to my account each year?

Generally, the law imposes a maximum limit on the amount of contributions (excluding catch-up contributions) that may be made to your account and any other amounts allocated to any of your accounts during the Plan Year, excluding earnings. Beginning in 2013, this total cannot exceed the lesser of \$51,000 or 100% of your annual compensation. After 2013, the dollar limit may increase for cost-of-living adjustments.

How is the money in the Plan invested?

The Trustee of the Plan has been designated to hold the assets of the Plan for the benefit of Plan participants and their beneficiaries in accordance with the terms of this Plan. The trust fund established by the Plan's Trustee will be the funding medium used for the accumulation of assets from which Plan benefits will be distributed.

Participant directed investments. You will be able to direct the investment of your entire interest in the Plan. The Administrator will provide you with information on the investment choices available to you, the procedures for making investment elections, the frequency with which you can change your investment choices and other important information. You need to follow the procedures for making investment elections and you should carefully review the information provided to you before you give investment directions. If you do not direct the investment of your applicable Plan accounts, then your accounts will be invested in accordance with the default investment alternatives established under the Plan.

The Plan is intended to comply with Section 404(c) of ERISA (the Employee Retirement Income Security Act). If the Plan complies with this Section, then the fiduciaries of the Plan, including your Employer, the Trustee and the Administrator, will be relieved of any legal liability for any losses which are the direct and necessary result of the investment directions that you give.

Earnings or losses. When you direct investments, your accounts are segregated for purposes of determining the earnings or losses on these investments. Your account does not share in the investment performance of other participants who have directed their own investments. You should remember that the amount of your benefits under the Plan will depend in part upon your choice of investments. Gains as well as losses can occur and your Employer, the Administrator, and the Trustee will not provide investment advice or guarantee the performance of any investment you choose.

Periodically, you will receive a benefit statement that provides information on your account balance and your investment returns. It is your responsibility to notify the Administrator of any errors you see on any statements within 30 days after the statement is provided or made available to you.

Will Plan expenses be deducted from my account balance?

Expenses allocated to all accounts. The Plan permits the payment of Plan expenses to be made from the Plan's assets. If expenses are paid using the Plan's assets, then the expenses will generally be allocated among the accounts of all participants in the Plan. These expenses will be allocated either proportionately based on the value of the account balances or as an equal dollar amount based on the number of participants in the Plan. The method of allocating the expenses depends on the nature of the expense itself. For example, certain administrative (or recordkeeping) expenses would typically be allocated proportionately to each participant. If the Plan pays \$1,000 in expenses and there are 100 participants, your account balance would be charged \$10 (\$1,000/100) of the expense.

Terminated employee. After you terminate employment, your Employer reserves the right to charge your account for your pro rata share of the Plan's administration expenses, regardless of whether your Employer pays some of these expenses on behalf of current employees.

Expenses allocated to individual accounts. There are certain other expenses that may be paid just from your account. These are expenses that are specifically incurred by, or attributable to, you. For example, if you are married and get divorced, the Plan may incur additional expenses if a court mandates that a portion of your account be paid to your ex-spouse. These additional expenses may be paid directly from your account (and not the accounts of other participants) because they are directly attributable to you under the Plan. The Administrator will inform you when there will be a charge (or charges) directly to your account.

Your Employer may, from time to time, change the manner in which expenses are allocated.

ARTICLE V VESTING

What is my vested interest in my account?

In order to reward employees who remain employed with the Employer for a long period of time, the law permits a "vesting schedule" to be applied to certain contributions that your Employer makes to the Plan. This means that you will not be entitled ("vested") in all of the contributions until you have been employed with the Employer for a specified period of time.

100% vested contributions. You are always 100% vested (which means that you are entitled to all of the amounts) in your accounts attributable to the following contributions:

- salary deferrals including Roth 401(k) deferrals and catch-up contributions
- rollover contributions
- matching contributions
- profit sharing contributions

What happens if the Plan becomes a "top-heavy plan"?

Top-heavy plan. A retirement plan that primarily benefits "key employees" is called a "top-heavy plan." Key employees are certain owners or officers of your Employer. A plan is generally a "top-heavy plan" when more than 60% of the plan assets are attributable to key employees. Each year, the Administrator is responsible for determining whether the Plan is a "top-heavy plan."

Top-heavy rules. If the Plan becomes top-heavy in any Plan Year, then non-key employees may be entitled to certain "top-heavy minimum benefits," and other special rules will apply. These top-heavy rules include the following:

- Your Employer may be required to make a contribution on your behalf in order to provide you with at least "top-heavy minimum benefits."
- If you are a participant in more than one Plan, you may not be entitled to "top-heavy minimum benefits" under both Plans.

ARTICLE VI DISTRIBUTIONS PRIOR TO TERMINATION AND HARDSHIP DISTRIBUTIONS

Can I withdraw money from my account while working?

In-service distributions. You may be entitled to receive an in-service distribution. However, this distribution is not in addition to your other benefits and will therefore reduce the value of the benefits you will receive at retirement. This distribution is made at your election and will be made in accordance with the forms of distributions available under the Plan.

Conditions and Limitations. Generally you may receive a distribution from the Plan from certain accounts prior to your termination of employment provided you satisfy any of the following conditions:

- you have attained age 59 1/2

The following limitations apply to in-service distributions from certain accounts:

- In-service distributions can only be made from accounts which are 100% vested.
- In-service distributions of your Roth 401(k) deferrals and earnings can only occur after the expiration of a 5-year participation period. The 5-year participation period is the 5-year period beginning on the calendar year in which you first make a Roth 401(k) deferral to our Plan (or to another 401(k) Plan or 403(b) plan if such amount was rolled over into our Plan) and ending on the last day of the calendar year that is 5 years later.

Account restrictions. You may request an in-service distribution only from the following accounts provided the account is 100% vested:

- pre-tax 401(k) deferral accounts
- Roth 401(k) deferral accounts
- account(s) attributable to Employer matching contributions
- accounts attributable to Employer profit sharing contributions

- rollover accounts (distributions may be made at any time)

Also, the law restricts any in-service distributions from certain accounts which are maintained for you under the Plan before you reach age 59 1/2. These accounts are the ones set up to receive your salary deferral contributions and other Employer contributions which are used to satisfy special rules for 401(k) plans. Ask the Administrator if you need more details.

Qualified reservist distributions. Effective as of 01/01/2009, if you were/are: (i) a reservist or National Guardsman; (ii) called to active duty after September 11, 2001; and (iii) called to duty for at least 180 days or for an indefinite period, you may take a distribution of your elective deferrals under the Plan while you are on active duty, regardless of your age. The 10% premature distribution penalty tax, normally applicable to Plan distributions made before you reach age 59 1/2, will not apply to the distribution. You also may repay the distribution to an IRA, without limiting amounts you otherwise could contribute to the IRA, provided you make the repayment within 2 years following your completion of active duty.

Can I withdraw money from my account in the event of financial hardship?

Hardship distributions. You may withdraw money for financial hardship if you satisfy certain conditions. This hardship distribution is not in addition to your other benefits and will therefore reduce the value of the benefits you will receive at retirement.

Qualifying expenses. A hardship distribution may be made to satisfy certain immediate and heavy financial needs that you have. A hardship distribution may only be made for payment of the following:

- Expenses for medical care (described in Section 213(d) of the Internal Revenue Code) previously incurred by you, your spouse, your dependents or your beneficiaries or necessary for you, your spouse, your dependents or your beneficiaries to obtain medical care.
- Costs directly related to the purchase of your principal residence (excluding mortgage payments),
- Tuition, related educational fees, and room and board expenses for the next twelve (12) months of post-secondary education for yourself, your spouse, your dependents or your beneficiaries.
- Amounts necessary to prevent your eviction from your principal residence or foreclosure on the mortgage of your principal residence.
- Payments for burial or funeral expenses for your deceased parent, spouse, children, other dependents or beneficiaries.
- Expenses for the repair of damage to your principal residence that would qualify for the casualty deduction under the Internal Revenue Code.

The ability to obtain a hardship distribution for certain expenses of your beneficiary is effective 01/01/2007. A beneficiary is someone you designate under the Plan to receive your death benefit who is not otherwise your spouse or dependent.

Conditions. If you have any of the above expenses, a hardship distribution can only be made if you certify and agree that all of the following conditions are satisfied:

- (a) The distribution is not in excess of the amount of your immediate and heavy financial need. The amount of your immediate and heavy financial need may include any amounts necessary to pay any federal, state, or local income taxes or penalties reasonably anticipated to result from the distribution;
- (b) You have obtained all distributions, other than hardship distributions, and all nontaxable loans currently available under all plans that your Employer maintains; and
- (c) That you will not make any salary deferrals for at least six (6) months after your receipt of the hardship distribution.

Limitations. The following limitations apply to hardship distributions:

- You must be employed with the Employer at the time of the hardship distribution.

Account restrictions. You may request a hardship distribution only from the vested portion of the following accounts:

- pre-tax 401(k) deferral accounts
- Roth 401(k) deferral accounts
- rollover accounts

In addition, there are restrictions placed on hardship distributions which are made from certain accounts. These accounts are the ones set up to receive your salary deferral contributions and other Employer contributions which are used to satisfy special rules that apply to 401(k) plans. Generally, the only amounts that can be distributed to you on account of a hardship from these accounts are your salary deferrals. The earnings on your salary deferrals and special Employer contributions may not be distributed to you on account of a hardship. Ask the Administrator if you need further details.

ARTICLE VII BENEFITS AND DISTRIBUTIONS UPON TERMINATION OF EMPLOYMENT

When can I get money out of the Plan?

You may receive a distribution of the vested portion of some or all of your accounts in the Plan for the following reasons:

- termination of employment for reasons other than death, disability or retirement
- early retirement
- normal retirement
- disability
- death

This Plan is designed to provide you with retirement benefits. However, distributions are permitted if you die or become disabled. In addition, certain payments are permitted when you terminate employment for any other reason. The rules under which you can receive a distribution are described in this Article. The rules regarding the payment of death benefits to your beneficiary are described in "Benefits and Distributions Upon Death."

You may also receive distributions while you are still employed with the Employer. (See the Article entitled "Distributions Prior to Termination and Hardship Distributions" for a further explanation.)

Military Service. If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with the Employer. There may also be benefits for employees who die or become disabled while on active duty. Employees who receive wage continuation payments while in the military may benefit from various changes in the law. If you think you may be affected by these rules, ask the Plan Administrator for further details.

Distributions for deemed severance of employment. If you are on active duty for more than 30 days, then, effective January 1, 2010, the Plan generally treats you as having severed employment for distribution purposes. This means that you may request a distribution from the Plan. If you request a distribution on account of this deemed severance of employment, then you are not permitted to make any contributions to the Plan for 6 (six) months after the date of the distribution.

What happens if I terminate employment before death, disability or retirement?

If your employment terminates for reasons other than early or normal retirement, you will be entitled to receive only the "vested percentage" of your account balance.

You may elect to have your vested account balance distributed to you as soon as administratively feasible following your termination of employment. However, if the value of your vested account balance does not exceed \$5,000, then a distribution will be made to you regardless of whether you consent to receive it. (See the question entitled "How will my benefits be paid to me?" for additional information.)

Treatment of rollovers for consent to distribution. In determining if the value of your vested account balance exceeds the \$5,000 threshold described above used to determine whether you must consent to a distribution, your rollover account will not be considered as part of your benefit.

What happens if I terminate employment at Normal Retirement Date?

Normal Retirement Date. You will attain your Normal Retirement Age when you reach your 65 birthday. Your Normal Retirement Date is the date on which you attain your Normal Retirement Age.

Payment of benefits. You will become 100% vested in all of your accounts under the Plan if you retire on or after your Normal Retirement Age. However, the actual payment of benefits generally will not begin until you have terminated employment and reached your Normal Retirement Date. In such event, a distribution will be made, at your election, as soon as administratively feasible. If you remain employed past your Normal Retirement Date, you may generally defer the receipt of benefits until you actually terminate employment. In such event, benefit payments will begin as soon as feasible at your request, but generally not later than age 70 1/2. (See the question entitled "How will my benefits be paid to me?" for an explanation of how these benefits will be paid.)

What happens if I terminate employment at Early Retirement Date?

Early Retirement Date. Your Early Retirement Date is the date you have attained age 55 and completed 0 Years of Service with your Employer. Your Years of Service will be determined using Years of Service for vesting. You may elect to retire when you reach your Early Retirement Date.

Payment of benefits. You will become 100% vested in all of your accounts under the Plan if you retire on or after your Early Retirement Date. However, the payment of benefits generally will not begin until you actually retire after reaching your Early Retirement Date. In such event, a distribution will be made, at your election, as soon as administratively feasible. However, if you retire after reaching your Early Retirement Date but prior to your Normal Retirement Date and the value of your account balance does not exceed \$5,000, then a distribution of your account balance will be made to you, regardless of whether you consent to receive it. (See the question entitled "How will my benefits be paid to me?" for an explanation of how these benefits will be paid.)

What happens if I terminate employment due to disability?

Definition of disability. Under the Plan, disability is defined as a physical or mental condition resulting from bodily injury, disease, or mental disorder which renders you incapable of continuing any gainful occupation and which has lasted or can be expected to last for a continuous period of at least twelve (12) months. Your disability must be determined by a licensed physician. However, if your condition constitutes total disability under the federal Social Security Act, then the Administrator may deem that you are disabled for purposes of the Plan.

Payment of benefits. If you become disabled while an employee, you will be entitled to your vested account balance under the Plan. Payment of your disability benefits will be made to you as if you had retired. However, if the value of your vested account balance does not exceed \$5,000, then a distribution of your vested account balance will be made to you, regardless of whether you consent to receive it. (See the question entitled "How will my benefits be paid to me?" for an explanation of how these benefits will be paid.)

How will my benefits be paid to me?

Forms of distribution. If your vested account balance does not exceed \$5,000, then your vested account balance may only be distributed to you in a single lump-sum payment. In determining whether your vested account balance exceeds the \$5,000 threshold, "rollovers" (and any earnings allocable to "rollover" contributions) will not be taken into account.

In addition, if your vested account balance exceeds \$5,000, you must consent to any distribution before it may be made. If your vested account balance exceeds \$5,000, you may elect to receive a distribution of your vested account balance in:

- a single lump-sum payment
- partial withdrawals or installments but only with respect to minimum required distributions, over a period of not more than your assumed life expectancy (or your and your beneficiary's assumed life expectancies). (See below "Delaying distributions." for an explanation of minimum required distributions.)

Delaying distributions. You may delay the distribution of your vested account balance unless a distribution is required to be made, as explained earlier, because your vested account balance does not exceed \$5,000. However, if you elect to delay the distribution of your vested account balance, there are rules that require that certain minimum distributions be made from the Plan. If you are a 5% owner, distributions are required to begin not later than the April 1st following the end of the year in which you reach age 70 1/2. If you are not a 5% owner, distributions are required to begin not later than the April 1st following the later of the end of the year in which you reach age 70 1/2 or retire. You should see the Administrator if you think you may be affected by these rules.

Medium of payment. Benefits under the Plan will generally be paid to you in cash.

ARTICLE VIII BENEFITS AND DISTRIBUTIONS UPON DEATH

What happens if I die while working for the Employer?

If you die while still employed by the Employer, then your vested account balance will be used to provide your beneficiary with a death benefit.

Who is the beneficiary of my death benefit?

Married Participant. If you are married at the time of your death, your spouse will be the beneficiary of the entire death benefit unless an election is made to change the beneficiary. IF YOU WISH TO DESIGNATE A BENEFICIARY OTHER THAN YOUR SPOUSE, YOUR SPOUSE MUST IRREVOCABLY CONSENT TO WAIVE ANY RIGHT TO THE DEATH BENEFIT. YOUR SPOUSE'S CONSENT MUST BE IN WRITING, BE WITNESSED BY A NOTARY OR A PLAN REPRESENTATIVE AND ACKNOWLEDGE THE SPECIFIC NONSPOUSE BENEFICIARY.

If you are married and you change your designation, then your spouse must again consent to the change. In addition, you may elect a beneficiary other than your spouse without your spouse's consent if your spouse cannot be located.

Unmarried Participant. If you are not married, you may designate a beneficiary on a form to be supplied to you by the Administrator.

Divorce. If you have designated your spouse as your beneficiary for all or a part of your death benefit, then upon your divorce, the designation is no longer valid. This means that if you do not select a new beneficiary after your divorce, then you are treated as not having a beneficiary for that portion of the death benefit (unless you have remarried).

No beneficiary designation. At the time of your death, if you have not designated a beneficiary or your beneficiary is also not alive, the death benefit will be paid in the following order of priority to:

- (a) your surviving spouse
- (b) your children, including adopted children in equal shares (and if a child is not living, that child's share will be distributed to that child's heirs)
- (c) your surviving parents, in equal shares
- (d) your estate

How will the death benefit be paid to my beneficiary?

Form of distribution. If the death benefit payable to a beneficiary does not exceed \$5,000, then the benefit may only be paid as a lump-sum. If the death benefit exceeds \$5,000, your beneficiary may elect to have the death benefit paid in:

- a single lump-sum payment
- partial withdrawals or installments that do not exceed the limitations on when the entire death benefit must be paid. (See below "When must the last payment be made to my beneficiary?")

When must the last payment be made to my beneficiary?

The law generally restricts the ability of a retirement plan to be used as a method of retaining money for purposes of your death estate. Thus, there are rules that are designed to ensure that death benefits are distributable to beneficiaries within certain time periods.

Regardless of the method of distribution selected, if your designated beneficiary is a person (rather than your estate or some trusts) then minimum distributions of your death benefit will begin by the end of the year following the year of your death ("1-year rule") and must be paid over a period not extending beyond your beneficiary's life expectancy. If your spouse is the beneficiary, then under the "1-year rule," the start of payments will be delayed until the year in which you would have attained age 70 1/2 unless your spouse elects to begin distributions over his or her life expectancy before then. However, instead of the "1-year rule" your beneficiary may elect to have the entire death benefit paid by the end of the fifth year following the year of your death (the "5-year rule"). Generally, if your beneficiary is not a person, your entire death benefit must be paid under the "5-year rule."

Since your spouse has certain rights to the death benefit, you should immediately report any change in your marital status to the Administrator.

What happens if I'm a participant, terminate employment and die before receiving all my benefits?

If you terminate employment with the Employer and subsequently die, your beneficiary will be entitled to your remaining interest in the Plan at the time of your death.

ARTICLE IX TAX TREATMENT OF DISTRIBUTIONS

What are my tax consequences when I receive a distribution from the Plan?

Generally, you must include any Plan distribution in your taxable income in the year in which you receive the distribution. The tax treatment may also depend on your age when you receive the distribution. Certain distributions made to you when you are under age 59 1/2 could be subject to an additional 10% tax.

You will not be taxed on distributions of your Roth 401(k) deferrals. In addition, a distribution of the earnings on the Roth 401(k) deferrals will not be subject to tax if the distribution is a "qualified distribution." A "qualified distribution" is one that is made after you have attained age 59 1/2 or is made on account of your death or disability. In addition, in order to be a "qualified distribution," the distribution cannot be made prior to the expiration of a 5-year participation period. The 5-year participation period is the 5-year period beginning on the calendar

year in which you first make a Roth 401(k) deferral to our Plan (or to another 401(k) plan or 403(b) plan if such amount was rolled over into our Plan) and ending on the last day of the calendar year that is 5 years later.

Qualified reservist distributions. Effective as of 01/01/2009, if you were/are: (i) a reservist or National Guardsman; (ii) called to active duty after September 11, 2001; and (iii) called to duty for at least 180 days or for an indefinite period, you may take a distribution of your elective deferrals under the Plan while you are on active duty, regardless of your age. The 10% premature distribution penalty tax, normally applicable to Plan distributions made before you reach age 59 1/2, will not apply to the distribution. You also may repay the distribution to an IRA, without limiting amounts you otherwise could contribute to the IRA, provided you make the repayment within 2 years following your completion of active duty.

Can I elect a rollover to reduce or defer tax on my distribution?

Rollover or Direct Transfer. You may reduce, or defer entirely, the tax due on your distribution through use of one of the following methods:

(a) **60-day rollover.** The rollover of all or a portion of the distribution to an Individual Retirement Account or Annuity (IRA) or another employer retirement plan willing to accept the rollover. This will result in no tax being due until you begin withdrawing funds from the IRA or other qualified employer plan. The rollover of the distribution, however, **MUST** be made within strict time frames (normally, within 60 days after you receive your distribution). Under certain circumstances, all or a portion of a distribution (such as a hardship distribution) may not qualify for this rollover treatment. In addition, most distributions will be subject to mandatory federal income tax withholding at a rate of 20%. This will reduce the amount you actually receive. For this reason, if you wish to roll over all or a portion of your distribution amount, then the direct transfer option described in paragraph (b) below would be the better choice.

(b) **Direct rollover.** For most distributions, you may request that a direct transfer (sometimes referred to as a direct rollover) of all or a portion of a distribution be made to either an Individual Retirement Account or Annuity (IRA) or another employer retirement plan willing to accept the transfer. A direct transfer will result in no tax being due until you withdraw funds from the IRA or other employer plan. Like the rollover, under certain circumstances all or a portion of the amount to be distributed may not qualify for this direct transfer. If you elect to actually receive the distribution rather than request a direct transfer, then in most cases 20% of the distribution amount will be withheld for federal income tax purposes.

Automatic IRA Rollover. If a mandatory distribution is being made to you because your vested interest in the Plan exceeds \$1,000 but does not exceed \$5,000, then the Plan will rollover your distribution to an IRA if you do not make an affirmative election to either receive or roll over the distribution. The IRA provider selected by the Plan will invest the rollover funds in a type of investment designed to preserve principal and provide a reasonable rate of return and liquidity (e.g., an interest-bearing account, a certificate of deposit or a money market fund). The IRA provider will charge your account for any expenses associated with the establishment and maintenance of the IRA and with the IRA investments. You may transfer the IRA funds to any other IRA you choose. You will be provided with details regarding the IRA at the time you are entitled to a distribution. Please see the attached Notice Regarding Automatic Rollovers for further information regarding the Plan's automatic rollover provisions, the IRA provider, and the fees and expenses associated with the IRA.

Tax Notice. WHENEVER YOU RECEIVE A DISTRIBUTION THAT IS AN ELIGIBLE ROLLOVER DISTRIBUTION, THE ADMINISTRATOR WILL DELIVER TO YOU A MORE DETAILED EXPLANATION OF THESE OPTIONS. HOWEVER, THE RULES WHICH DETERMINE WHETHER YOU QUALIFY FOR FAVORABLE TAX TREATMENT ARE VERY COMPLEX. YOU SHOULD CONSULT WITH QUALIFIED TAX COUNSEL BEFORE MAKING A CHOICE.

ARTICLE X LOANS

Is it possible to borrow money from the Plan?

Yes, you may request a participant loan from all your accounts using an application form provided by the Administrator. Your ability to obtain a participant loan depends on several factors. The Administrator will determine whether you satisfy these factors.

What are the loan rules and requirements?

There are various rules and requirements that apply to any loan, which are outlined in this question. In addition, your Employer has established a written loan program which explains these requirements in more detail. You can request a copy of the loan program from the Administrator. Generally, the rules for loans include the following:

- Loans are available to participants on a reasonably equivalent basis. Loans will be made to participants who are creditworthy. The Administrator may request that you provide additional information, such as financial statements, tax returns and credit reports to make this determination.
- All loans must be adequately secured. You must sign a promissory note along with a loan pledge. Generally, you must use your vested interest in the Plan as security for the loan, provided the outstanding balance of all your loans does not exceed 50% of your vested interest in the Plan. In certain cases, the Administrator may require you to provide additional collateral to receive a loan.

- You will be charged an interest rate equal to 1% above the prime rate. The interest rate will be fixed for the duration of the loan.
- If approved, your loan will provide for level amortization with payments to be made not less frequently than quarterly. Generally, the term of your loan may not exceed five (5) years. However, if the loan is for the purchase of your principal residence, the Administrator may permit a longer repayment term. Generally, the Administrator will require that you repay your loan by agreeing to either payroll deduction or payment by check. If you have an unpaid leave of absence or go on military leave while you have an outstanding loan, please contact the Administrator to find out your repayment options.
- All loans will be considered a directed investment of your account under the Plan. All payments of principal and interest by you on a loan will be credited to your account.
- The amount the Plan may loan to you is limited by rules under the Internal Revenue Code. Any new loans, when added to the outstanding balance of all other loans from the Plan, will be limited to the lesser of:
 - (a) \$50,000 reduced by the excess, if any, of your highest outstanding balance of loans from the Plan during the one-year period ending on the day before the date of the new loan over your current outstanding balance of loans as of the date of the new loan; or
 - (b) 1/2 of your vested interest in the Plan.
- No loan in an amount less than \$1000 will be made.
- The maximum number of Plan loans that you may have outstanding at any one time is 1.
- If you fail to make payments when they are due under the terms of the loan, you will be considered to be "in default." The Administrator will consider your loan to be in default if any scheduled loan repayment is not made by the end of the calendar quarter following the calendar quarter in which the missed payment was due. The Plan would then have authority to take all reasonable actions to collect the balance owed on the loan. This could include filing a lawsuit or foreclosing on the security for the loan. Under certain circumstances, a loan that is in default may be considered a distribution from the Plan and could be considered taxable income to you. In any event, your failure to repay a loan will reduce the benefit you would otherwise be entitled to from the Plan.

The Administrator may periodically revise the Plan's loan policy. If you have any questions on participant loans or the current loan policy, please contact the Administrator.

ARTICLE XI PROTECTED BENEFITS AND CLAIMS PROCEDURES

Are my benefits protected?

As a general rule, your interest in your account, including your "vested interest," may not be alienated. This means that your interest may not be sold, used as collateral for a loan (other than for a Plan loan), given away or otherwise transferred. In addition, your creditors (other than the IRS) may not attach, garnish or otherwise interfere with your benefits under the Plan.

Are there any exceptions to the general rule?

There are three exceptions to this general rule. The Administrator must honor a "qualified domestic relations order." A "qualified domestic relations order" is defined as a decree or order issued by a court that obligates you to pay child support or alimony, or otherwise allocates a portion of your assets in the Plan to your spouse, former spouse, children or other dependents. If a qualified domestic relations order is received by the Administrator, all or a portion of your benefits may be used to satisfy that obligation. The Administrator will determine the validity of any domestic relations order received. You and your beneficiaries can obtain from the Administrator, without charge, a copy of the procedure used by the Administrator to determine whether a qualified domestic relations order is valid.

The second exception applies if you are involved with the Plan's operation. If you are found liable for any action that adversely affects the Plan, the Administrator can offset your benefits by the amount that you are ordered or required by a court to pay the Plan. All or a portion of your benefits may be used to satisfy any such obligation to the Plan.

The last exception applies to Federal tax levies and judgments. The Federal government is able to use your interest in the Plan to enforce a Federal tax levy and to collect a judgment resulting from an unpaid tax assessment.

Can the Plan be amended?

Your Employer has the right to amend the Plan at any time. In no event, however, will any amendment authorize or permit any part of the Plan assets to be used for purposes other than the exclusive benefit of participants or their beneficiaries. Additionally, no amendment will cause any reduction in the amount credited to your account.

What happens if the Plan is discontinued or terminated?

Although your Employer intends to maintain the Plan indefinitely, your Employer reserves the right to terminate the Plan at any time. Upon termination, no further contributions will be made to the Plan and all amounts credited to your accounts will continue to be 100% vested. Your Employer will direct the distribution of your accounts in a manner permitted by the Plan as soon as practicable. (See the question entitled "How will my benefits be paid to me?" for a further explanation.) You will be notified if the Plan is terminated.

How do I submit a claim for Plan benefits?

Benefits will generally be paid to you and your beneficiaries without the necessity for formal claims. Contact the Administrator if you are entitled to benefits or if you think an error has been made in determining your benefits. Any such request should be in writing.

If the Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

What if my benefits are denied?

Your request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If your claim is wholly or partially denied, the Administrator will provide you with a written or electronic notification of the Plan's adverse determination. This written or electronic notification must be provided to you within a reasonable period of time, but not later than 90 days after the receipt of your claim by the Administrator, unless the Administrator determines that special circumstances require an extension of time for processing your claim. If the Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 90-day period. In no event will such extension exceed a period of 90 days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

In the case of a claim for disability benefits, if disability is determined by a physician (rather than relying upon a determination of disability for Social Security purposes), then instead of the above, the Administrator will provide you with written or electronic notification of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any such extension, the notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days within which to provide the specified information.

The Administrator's written or electronic notification of any adverse benefit determination must contain the following information:

- (a) The specific reason or reasons for the adverse determination.
- (b) Reference to the specific Plan provisions on which the determination is based.
- (c) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.
- (d) Appropriate information as to the steps to be taken if you or your beneficiary want to submit your claim for review.
- (e) In the case of disability benefits where disability is determined by a physician:
 - (i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request.
 - (ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request.

If your claim has been denied, and you want to submit your claim for review, you must follow the Claims Review Procedure in the next question.

What is the Claims Review Procedure?

Upon the denial of your claim for benefits, you may file your claim for review, in writing, with the Administrator.

(a) YOU MUST FILE THE CLAIM FOR REVIEW NO LATER THAN 60 DAYS AFTER YOU HAVE RECEIVED WRITTEN NOTIFICATION OF THE DENIAL OF YOUR CLAIM FOR BENEFITS.

HOWEVER, IF YOUR CLAIM IS FOR DISABILITY BENEFITS AND DISABILITY IS DETERMINED BY A PHYSICIAN, THEN INSTEAD OF THE ABOVE, YOU MUST FILE THE CLAIM FOR REVIEW NO LATER THAN 180 DAYS FOLLOWING RECEIPT OF NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION.

(b) You may submit written comments, documents, records, and other information relating to your claim for benefits.

(c) You may review all pertinent documents relating to the denial of your claim and submit any issues and comments, in writing, to the Administrator.

(d) You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

(e) Your claim for review must be given a full and fair review. This review will take into account all comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition to the Claims Review Procedure above, if your claim is for disability benefits and disability is determined by a physician, then the Claims Review Procedure provides that:

(a) Your claim will be reviewed without deference to the initial adverse benefit determination and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

(b) In deciding an appeal of any adverse benefit determination that is based in whole or part on medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

(c) Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination will be identified, without regard to whether the advice was relied upon in making the benefit determination.

(d) The health care professional engaged for purposes of a consultation under (b) above will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Administrator will provide you with written or electronic notification of the Plan's benefit determination on review. The Administrator must provide you with notification of this denial within 60 days after the Administrator's receipt of your written claim for review, unless the Administrator determines that special circumstances require an extension of time for processing your claim. If the Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 60-day period. In no event will such extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review. However, if the claim relates to disability benefits and disability is determined by a physician, then 45 days will apply instead of 60 days in the preceding sentences. In the case of an adverse benefit determination, the notification will set forth:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the benefit determination is based.

(c) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

(d) In the case of disability benefits where disability is determined by a physician:

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request.

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request.

If you have a claim for benefits which is denied, then you may file suit in a state or Federal court. However, in order to do so, you must file the suit no later than 180 days after the Administrator makes a final determination to deny your claim.

What are my rights as a Plan participant?

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

- (a) Examine, without charge, at the Administrator's office and at other specified locations, all documents governing the Plan and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- (b) Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- (c) Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to \$110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. You and your beneficiaries can obtain, without charge, a copy of the qualified domestic relations order ("QDRO") procedures from the Administrator.

If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. The court may order you to pay these costs and fees if you lose or if, for example, it finds your claim is frivolous.

What can I do if I have questions or my rights are violated?

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

ARTICLE XII GENERAL INFORMATION ABOUT THE PLAN

There is certain general information which you may need to know about the Plan. This information has been summarized for you in this Article.

Plan Name

The full name of the Plan is Oaktree Capital Management, L.P. 401(k) Savings Plan.

Plan Number

Your Employer has assigned Plan Number 001 to your Plan.

Plan Effective Dates

This Plan was originally effective on June 1, 1995. The amended and restated provisions of the Plan become effective on January 1, 2012.

Other Plan Information

Valuations of the Plan assets are generally made every business day. Certain distributions are based on the Anniversary Date of the Plan. This date is the last day of the Plan Year.

The Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1st and ends on December 31st.

The Plan and Trust will be governed by the laws of Delaware to the extent not governed by federal law.

Benefits provided by the Plan are NOT insured by the Pension Benefit Guaranty Corporation (PBGC) under Title IV of the Employee Retirement Income Security Act of 1974 because the insurance provisions under ERISA are not applicable to this type of Plan.

Service of legal process may be made upon your Employer. Service of legal process may also be made upon the Trustee or Administrator.

Employer Information

Your Employer's name, address and identification number are:

Oaktree Capital Management, L.P.
333 South Grand Avenue 28th Floor
Los Angeles, California 90071
26-0189082

The Plan allows other employers to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of employers, if any, who have adopted the Plan by making a written request to the Administrator.

Plan Administrator Information

The Plan Administrator is responsible for the day-to-day administration and operation of the Plan. For example, the Administrator maintains the Plan records, including your account information, provides you with the forms you need to complete for Plan participation, and directs the payment of your account at the appropriate time. The Administrator will also allow you to review the formal Plan document and certain other materials related to the Plan. If you have any questions about the Plan or your participation, you should contact the Administrator. The Administrator may designate other parties to perform some duties of the Administrator.

The Administrator has the complete power, in its sole discretion, to determine all questions arising in connection with the administration, interpretation, and application of the Plan (and any related documents and underlying policies). Any such determination by the Administrator is conclusive and binding upon all persons.

The name, address and business telephone number of the Plan's Administrator are:

Oaktree Capital Management, L.P.
333 South Grand Avenue 28th Floor
Los Angeles, California 90071
213-830-6248

Plan Trustee Information and Plan Funding Medium

All money that is contributed to the Plan is held in a trust fund. The Trustee is responsible for the safekeeping of the trust fund. The trust fund established by the Plan's Trustee(s) will be the funding medium used for the accumulation of assets from which benefits will be distributed. While all the Plan assets are held in a trust fund, the Administrator separately accounts for each Participant's interest in the Plan.

The Plan's Trustee is:

Charles Schwab Trust Company
215 Fremont Street, 6th Floor
San Francisco, California 94105

**APPENDIX
PLAN EXPENSE ALLOCATIONS**

The Plan will assess against an individual participant's account the following Plan expenses which are incurred by, or are attributable to, a particular participant based on use of a particular Plan feature, listed by type and the amount charged (*check all that apply, and fill in the charge or method of determining the charge*). All fees are subject to change.

☒ **Participant loan.** Participant loan fees.

Amount of application fee (includes processing and document preparation): \$ 100.00

Amount of annual maintenance fee: \$ 0.00

APPENDIX
ROLLOVERS FROM OTHER PLANS

The Plan will accept participant rollover contributions and/or direct rollovers of distributions from the types of plans specified below:

Direct Rollovers. The Plan will accept a direct rollover of an eligible rollover distribution from:

- ☒ a qualified plan described in section 401(a) of the Internal Revenue Code (including a 401(k) plan, profit sharing plan, defined benefit plan, stock bonus plan and money purchase plan), **excluding** after-tax employee contributions.
- ☐ a qualified plan described in section 401(a) of the Internal Revenue Code (including a 401(k) plan, profit sharing plan, defined benefit plan, stock bonus plan and money purchase plan), **including** after-tax employee contributions.
- ☒ a qualified plan described in section 403(a) of the Internal Revenue Code (an annuity plan), **excluding** after-tax employee contributions.
- ☐ a qualified plan described in section 403(a) of the Internal Revenue Code (an annuity plan), **including** after-tax employee contributions.
- ☒ an annuity contract described in section 403(b) of the Internal Revenue Code (a tax-sheltered annuity), **excluding** after-tax employee contributions.
- ☐ an annuity contract described in section 403(b) of the Internal Revenue Code (a tax-sheltered annuity), **including** after-tax employee contributions.
- ☒ a plan described in section 457(b) of the Internal Revenue Code (eligible deferred compensation plan).
- ☒ a Roth elective deferral account under a qualified plan described in section 401(a) of the Internal Revenue Code (a 401(k) plan).
- ☒ a Roth elective deferral account under an annuity contract described in section 403(b) of the Internal Revenue Code (a tax-sheltered annuity).

Participant Rollover Contributions from Other Plans. The Plan will accept a participant contribution of an eligible rollover distribution: (Check each that applies or none.)

- ☒ a qualified plan described in section 401(a) of the Internal Revenue Code (including a 401(k) plan, profit sharing plan, defined benefit plan, stock bonus plan and money purchase plan).
- ☒ a qualified plan described in section 403(a) of the Internal Revenue Code (an annuity plan).
- ☒ an annuity contract described in section 403(b) of the Internal Revenue Code (a tax-sheltered annuity).
- ☒ a plan described in Code Section 457(b) (eligible deferred compensation plan).

Participant Rollover Contributions from IRAs:

- ☒ The Plan will accept a participant rollover contribution of the portion of a distribution from a traditional IRA that is eligible to be rolled over and would otherwise be includible in gross income. Rollovers from Roth IRAs or a Coverdell Education Savings Account (formerly known as an Education IRA) are not permitted because they are not traditional IRAs. A rollover from a SIMPLE IRA is allowed if the amounts are rolled over after the participant has been in the SIMPLE IRA for at least two years.

NOTICE REGARDING AUTOMATIC ROLLOVER

Oaktree Capital Management, L.P. 401(k) Savings Plan

This Notice is being provided to you regarding the Automatic Rollover provisions discussed in Article IX of the plan's SPD.

Please note that the automatic rollover provisions will apply to all amounts of \$5,000 or less.

At an appropriate time after you terminate employment, we will send you a distribution form for you to make an election on how you would like your benefits to be paid. You have several choices with respect to the distribution you will receive. You may elect to either:

1. Take the distribution and include it in income; or
2. Have the distribution rolled over to either a qualified retirement plan or an Individual Retirement Account ("IRA").

You have thirty (30) days after receipt of this Notice to complete and return the form advising the Plan Administrator of your election. Under the law, if you fail to notify the Plan Administrator of your decision, your vested account balance will be rolled over into an IRA. The Plan Sponsor has the authority to execute the documents necessary to establish this account, using your most recent mailing address. Should you not wish this automatic rollover to occur, it is imperative that you respond to all communications from the Plan Administrator regarding the disposition of your Plan Account.

The Plan has selected the following Trustee/Issuer:

Name: TDAmeritrade, Inc.

You will have the right to transfer your IRA to any other IRA provider, once the IRA has been established.

It is important that you respond to any correspondence received from the Plan Administrator and advise them of any change of address. Should you have any questions, please contact the Plan Administrator.

The Initial IRA setup fee shall be: \$0.00

The Initial IRA setup fee shall be paid by: The Company

The IRA Provider's annual fee shall be: \$0.00

The IRA funds shall be invested in: TDAM Money Market Portfolio Class A Fund

For inquiries regarding the automatic rollover process, Participants can contact:

Name: Plan Administrator

Address:

333 South Grand Avenue
28th Floor
Los Angeles, CA 90071

Phone No: 213-830-6300