HERTZ CUSTOM BENEFIT PROGRAM

As Amended and Restated Effective July 1, 2019

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HERTZ CUSTOM BENEFIT PROGRAM

ARTICLE I
ESTABLISHMENT AND PURPOSE

Section 1.01 Establishment. The Hertz Corporation (the "Company") has established and maintains the Hertz Custom Benefit Program (the "Plan") for eligible Employees of an Employer. This amendment and restatement of the Plan is effective July 1, 2019. The Plan was originally effective July 1, 1987. The Plan is a consolidation, amendment and restatement of various employee welfare benefit plans maintained by the Company and set forth in the relevant summary plan descriptions and related plan documents, including the follows:

- Hertz Travel Accident Insurance Plan;
- Hertz Short Term Disability Plans;
- Hertz Voluntary Benefits Program; and
- Hertz Adoption Assistance Program.

Section 1.02 Purpose. The purpose of the Plan is: (i) to offer eligible Employees, and for the purposes of COBRA former Employees, an opportunity to obtain certain welfare benefits, as specified in Appendix A; (ii) to provide eligible Employees an opportunity to pay for certain benefits on a pre-tax basis; and (iii) to provide eligible Employees an opportunity to fund certain unreimbursed medical care expenses and certain qualifying dependent care expenses. Benefits are provided under the Plan through a number of Benefit Programs.

The Plan is to be administered and interpreted in a manner consistent with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), applicable provisions of the Internal Revenue Code of 1986, as amended (the "Code"), including the requirements of Sections 79, 105(h), 125, 129, 137 and 9815 of the Code, the Public Health Service Act (the "PHS Act"), and the regulations promulgated thereunder. Nothing in this Plan document, however, will subject any Benefit Program to ERISA if the Benefit Program would not otherwise be covered by ERISA. The Benefit Programs not subject to ERISA are identified in Appendix A.

Section 1.03 Benefit Programs. The Plan consolidates a broad range of welfare plan benefits (as defined in Section 3(1) of ERISA) and a Cafeteria Program within the meaning of Section 125 of the Code. The Cafeteria Program includes, among other benefits, a "dependent care assistance plan" (as defined in Section 129 of the Code), a health flexible spending account (within the meaning of Section 125 of the Code), and a "self-insured medical reimbursement plan" (as defined in Section 105 of the Code).

Benefits are provided to Participants and their respective covered Dependents through one or more Benefit Programs sponsored or maintained by one or more of the Employers. Such Benefit Programs may be funded or unfunded, insured or uninsured, or a combination thereof, and may provide varying benefits to different groups of current and former Employees of the Employers and their respective covered Dependents. The separate Benefit Programs that are consolidated into the Plan are listed in Appendix A. Separate Program Documents which describe the specific

benefits provided by each Benefit Program, the individuals covered by each Benefit Program, and the other terms and conditions of each Benefit Program, as amended from time to time, are incorporated herein by reference. The Plan supersedes and replaces any document defining the terms of or describing a Benefit Program which is not incorporated and made part of the Plan. Except as provided in Section 14.01, if the Benefit Program is insured and there is a conflict between the specific terms of a Program Document issued by an Insurance Company and the terms of the Plan, the Program Document will control; however, for purposes of Section 14.01, this Plan document will control. For all other Benefit Programs, if there is a conflict between the specific terms of a Program Document and the terms of the Plan, the Plan will control (unless contrary to applicable law), except that any terms exclusively applicable to a Benefit Program will be set forth in the applicable Program Document.

Section 1.04 Annual Reporting Requirements. All Benefit Programs offered under the Plan will constitute a single plan for purposes of the annual reporting requirements of the Code and ERISA. Notwithstanding the foregoing, any separate Benefit Program required to receive an opinion from an independent qualified public accountant pursuant to Section 103(a)(3) of ERISA will be deemed a separate employee benefit plan for purposes of the annual reporting requirement of the Code and ERISA.

Section 1.05 Applicability of Plan. The Plan as amended and restated will apply only to eligible individuals who are Participants on or after July 1, 2019.

Section 1.06 Compliance with the Affordable Care Act. Notwithstanding anything in the Plan to the contrary, the Plan will comply with the applicable requirements of the Affordable Care Act, as such requirements become effective from time to time with respect to the Plan, and the Plan is to be administered and interpreted in a manner consistent therewith.

ARTICLE II
DEFINITIONS

Whenever used in the Plan, the following words and phrases will have the respective meanings specified in this Section unless the context plainly requires a different meaning, and when the defined meaning is intended the term will be capitalized in the Plan.

Section 2.01 Account means a bookkeeping record maintained by the Plan under Articles VII, VIII and IX with respect to each Participant which reflects, from time to time, the amounts attributable to Compensation reduction contributions made on the Participant's behalf, subject to any distributions or forfeitures incurred. The Accounts will not be funded and will not earn or accrue any interest for the benefit of any Participant.

(a) **Dependent Care Spending Account** means the Account established for a Participant to record the contributions which the Participant has elected to make to such Account and the reimbursements made to such Participant for eligible Dependent Care Expenses.

(b) **Health Care Spending Account** means the Account established and maintained for a Participant to record the contribution that the Participant has elected to make to such Account and the reimbursements made to such Participant for eligible Medical Care Expenses.

(c) **Health Reimbursement Account** means the Account established and maintained for a Participant to record the allocations an Employer makes to such Account and the reimbursements made to such Participant for eligible Medical Care Expenses.

Section 2.02 Administrator means the Company, other entity or individual designated from time to time by the Compensation Committee of the Board of Directors of the Company to supervise the administration of the Plan in accordance with Article XIII.

Section 2.03 Adoption Expenses means any reasonable and necessary adoption fees, court costs, attorneys' fees, and other expenses that are incurred by a Participant which directly relate to, and the principal purpose of which is for, the legal adoption of an Eligible Child by the Participant. The following are examples of Adoption Expenses:

(a) Private or public adoption agency fees;

(b) Hospitalization and other medical costs of the natural (birth) mother and child if the Participant legally assumes such costs under the terms and conditions of the adoption agreement;

(c) Court costs;

(d) Attorneys' fees; and

(e) Placement fees.

The term Adoption Expenses does not include costs:

(i) Incurred in violation of any law or in carrying out any surrogate parenting arrangement; or

(ii) Reimbursed under another Company plan or program, under a Participant's spouse's employer's plans or benefits, or by any other Third Party.

Section 2.04 Affiliate means any corporation or other business entity which is (i) a member of a controlled group of corporations (within the meaning of Section 414(b) of the Code) of which the Company is also a member; (ii) a trade or business under common control with the Company, within the meaning of Section 414(c) of the Code; (iii) a member of an affiliated service group (within the meaning of Section 414(m) of the Code) of which the Company is also a member; or (iv) required to be aggregated with the Company pursuant to regulations issued under Section 414(o) of the Code; provided that no such corporation or other business entity shall be considered an Affiliate at any time prior or subsequent to the time during which it meets the above definition and, provided further, that the status of being employed by an Affiliate shall pertain to an individual only during the time when his or her employer is an Affiliate and not to any time prior or subsequent to its Affiliate status.

Section 2.05 Affordable Care Act means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, as such amends the applicable provisions of the Code, ERISA, and the PHS Act, and the applicable regulations promulgated from time to time pursuant thereto.

Section 2.06 Benefit Program means a separate welfare plan program which is sponsored by an Employer and which forms part of the Plan. A Benefit Program will also include the Cafeteria Program, the terms and conditions of which are specified herein. A Benefit Program may be governed in whole or in part by a collective bargaining agreement to the extent such agreement provides for welfare benefits covered by a Benefit Program. The Administrator will maintain records as to the particular Benefit Programs from time to time forming part of the Plan and which are listed on Appendix A or identified in a summary plan description.

Section 2.07 Cafeteria Program means the Benefits Program set forth herein which permits eligible Employees to choose between certain benefits provided by the Employer, including contributions to a health savings account as defined under Section 223 of the Code, or additional cash compensation, as described in Article IV. The Cafeteria Program is intended to qualify as a "cafeteria plan" under Section 125 of the Code and only qualified benefits as defined in Section 125(f) of the Code will be offered under the Cafeteria Program.

Section 2.08 Change in Status means one of the following events, as well as any other event included under subsequent changes to regulations issued under Section 125 of the Code which the Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis:

(a) an event that changes the Employee's legal marital status, including marriage, death of the Employee's Spouse, divorce, legal separation or annulment;

(b) a change in the number of the Employee's Section 152 Dependents, including the birth, adoption, placement for adoption (as defined under HIPAA), or death of a Section 152 Dependent;

(c) any change in employment status of the Participant or the Participant's Section 152 Dependent that affects benefit eligibility under a Benefit Program, including: the termination or commencement of employment; strike or lockout; the commencement of or return from an unpaid leave of absence; a change in residence or worksite that would affect the Employee's eligibility for coverage; or a change in employment status that causes the individual to become or cease to be eligible under a Benefit Program (e.g., switching from part-time to full-time status or vice versa, or a similar change if such change causes the individual to lose eligibility for coverage);

(d) a change in employment or marital status that causes the Employee to become eligible for coverage under his or her Spouse's or Section 152 Dependent's plan if the Employee actually obtains coverage thereunder;

(e) an event that causes a Section 152 Dependent to satisfy or cease to satisfy the eligibility requirements for a particular Benefit Program including, but not limited to, attaining a specified age, getting married, or ceasing to be a student;

(f) a change in employment status of a Spouse or Section 152 Dependent which results in a loss of coverage under the Spouse's or Section 152 Dependent's plan;

(g) a change in the residence of the Employee or Section 152 Dependent; or

(h) any other event recognized for purposes of changing Plan elections under applicable law and regulations.

See Section 5.06 for requirements that must be met for a Participant to change his or her election during the Plan Year on account of Change in Status.

Section 2.09 Claimant means any person who believes he or she is entitled to receive a benefit under the Plan and files a claim in accordance with Article XIV.

Section 2.10 Claims Administrator (or "Claims Fiduciary") means an Insurance Company or other party that has contracted with an Employer to provide claim administration services to a Benefit Program or is responsible for determining whether a particular claim is covered by such Benefit Program. If no other individual or entity is designated as Claims Administrator for a Benefit Program, the Administrator will be the Claims Administrator.

Section 2.11 COBRA means the coverage rights conferred by Section 4980B, *et seq.* of the Code, as amended from time to time, and Section 601, *et seq.* of ERISA, as amended from time to time (as such statutes were created by Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, and have been amended thereafter), and the applicable regulations issued and effective thereunder.

Section 2.12 Code means the Internal Revenue Code of 1986, as amended from time to time, and applicable regulations issued and effective thereunder.

Section 2.13 Committee means the Hertz Benefits Committee, as designated by the Compensation Committee of the Company. The Committee shall consist of the individuals from time to time serving in the following Company offices: (i) Chief Financial Officer; (ii) Chief Human Resources Officer; (iii) Treasurer; (iv) Vice President, Labor Relations Human Resources Practices; and (v) General Counsel. In the event of a change in title, the continuing Committee member shall be the individual whose title encompasses the Plan related duties previously the responsibility of the person holding the prior title; with any uncertainty resolved by the Compensation Committee of the Board of Directors of the Company.

Section 2.14 Company means The Hertz Corporation and any successor or assign thereof which adopts the Plan by action of its governing body or which contractually assumes the obligations of the Company under the Plan.

Section 2.15 Compensation means the base pay received by an Employee from an Employer for the period of coverage except that:

(a) in the case of a Participant who resides in Hawaii, Compensation means all remuneration received from an Employer for a period of coverage including, but not limited to, wages, commissions and bonuses; and

(b) in the case of a salesperson who works on a commission basis and has been employed for at least 12 months, Compensation means the greater of: (i) 80% of the annualized W-2 earnings for the previous year; or (ii) base pay.

If a Participant elects to pay for COBRA continuation coverage as provided in Section 11.01(f)(v), compensation will include severance payments.

Section 2.16 Concurrent Care Claim means, with respect to an ongoing course of treatment to be provided over a period of time or number of treatments, a Health Care Claim to extend such ongoing course of treatment beyond the period of time or number of treatments authorized by the Administrator or Claims Administrator.

Section 2.17 Covered Person means any Participant or Dependent who is covered under Benefit Program and who is eligible to receive benefits in accordance with the terms of the applicable Benefit Program.

Section 2.18 Dependent means the Participant's Spouse and any other individual who meets the definition of a dependent set forth in the Program Document for a particular Benefit Program. Notwithstanding the foregoing, individuals who are otherwise "Dependents" will not be eligible for coverage under the Plan if they serve in the military of any country or reside outside of the United States or Canada. Dependent may include:

(a) the Participant's Spouse;

(b) the Participant's Domestic Partner;

(c) a natural child, stepchild, foster child or legally adopted child (or child placed for adoption) of the Participant, the Participant's Spouse or the Participant's Domestic Partner, until the child turns age 26;

(d) for purposes of the Health Care Spending Account and any other Benefit Program providing medical care, Dependent may include any other individual not described in (a) or (b) above who:

(i) is a Section 152 Dependent; or

(ii) is determined to be an alternate recipient of a Participant under a QMCSO.

Section 2.19 Dependent Care Expenses means expenses described in Section 8.04.

Section 2.20 Domestic Partner means an individual who has a committed relationship with the Participant, provided that the Participant and the Domestic Partner certify that they are:

(a) in a continuous committed relationship with each other for no less than six (6) months, are each other's sole domestic partner and intend to remain so indefinitely;

(b) living in the same household;

(c) both at least age 18, of legal age and legally competent to consent and to enter into a contract;

(d) not married to someone else;

(e) not the domestic partner of someone else;

(f) not related by blood to a degree of kinship which would prohibit legal marriage under state law in the state of residence; and

(g) jointly responsible for each other's common welfare and share financial obligations.

Notwithstanding the foregoing, to the extent the above criteria are satisfied, or where required by law, "Domestic Partner" may include a civil union partner or common law spouse under state law. Participants seeking to enroll a Domestic Partner may be required to complete an affidavit and/or provide substantiating evidence of Domestic Partnership.

Section 2.21 Effective Date means July 1, 2019, which is the date on which the restatement of the Plan became effective.

Section 2.22 Election Form means such form as the Administrator may approve from time to time for the purpose of enrolling in the Plan or changing or revoking an election. An Election Form may be written, electronic, or voice response.

Section 2.23 Eligible Child means any individual who has not reached the age of 18 and is not the blood relative or previously adopted child of the Participant or his or her Spouse.

Section 2.24 Employee means an individual who is treated as a regular employee of an Employer (a) who is paid a salary, wages or other compensation by an Employer; (b) who is considered by an Employer to be an employee at the time of the payment of such salary, wages, or other compensation; and (c) whose salary, wages or other compensation is treated by an Employer at the time of such payment as being subject to statutorily required payroll tax withholding, such as withholding of federal or state income or withholding of the employee's share of social security tax.

All other individuals will not be included within the definition of "Employee", even if one or more of such other individuals is determined by a court, the Internal Revenue Service or any other entity under any federal or state law, rule or regulation to be (or have been) a common law or statutory employee of an Employer for some or all of the period of time in question. Without limiting who is excluded, the following individuals are expressly excluded from the definition of the term "Employee":

(a) any nonresident alien employee who does not have U.S.-source income from the Employer;

(b) any employee who normally works in Puerto Rico, the U.S. Virgin Islands or elsewhere outside the United States;

(c) any employee who normally works outside the United States but is in the United States on temporary assignment to an Employer, but only to the extent such employee is covered by a plan maintained outside the United States by the Company or an Affiliate;

(d) any individual who is performing services for an Employer under an independent contractor or consultant agreement or arrangement with an Employer (even if a court, the Internal Revenue Service, or any other entity determines that such individual is a common law employee);

(e) any individual who must be treated as an employee of an Employer for limited purposes under the leased employee provisions of Section 414(n) of the Code;

(f) any individual covered by a collective bargaining agreement that does not provide for coverage under the Plan, provided that the type of benefits provided under the Plan was the subject of good faith bargaining between the individual's bargaining representative and an Employer;

(g) any employee in a job category, division, location or operation with respect to which the Plan has not been adopted or to which coverage has not been extended, unless such individual is required to be offered coverage under the Affordable Care Act's Employer Shared Responsibility requirement, in which case the Plan can choose to extend coverage to such individual;

(h) any individual providing services to an Employer pursuant to an agreement between the Employer and a third party (even if a court, the Internal Revenue Service, or any other entity determines that such individual is a common law employee); or

(i) a person who performs services for an Employer but who is treated for payroll purposes as other than an Employee of the Employer (even if a court, the Internal Revenue Service, or any other entity determines that such individual is a common law employee).

Section 2.25 Employer means any Affiliate that participates in the Plan pursuant to the procedures outlined in Article XVI.

Section 2.26 ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and the applicable regulations issued and effective thereunder.

Section 2.27 FMLA means the Family and Medical Leave Act of 1993, as amended from time to time, and the applicable regulations issued and effective thereunder.

Section 2.28 Grace Period means the period from the end of a Plan Year up to and including the fifteenth day of the third calendar month after the end of that Plan Year.

Section 2.29 Health Care Claim means a request by a Claimant for a benefit under a Benefit Program that is a group health plan (*i.e.*, an employee welfare benefit plan within the meaning of Section 3(1) of ERISA to the extent that such plan provides "medical care" within the meaning of Section 733(a) of ERISA) that is made in accordance with the rules and procedures established by the Claims Administrator.

Section 2.30 Highly Compensated Participant means a Participant who is a "highly compensated participant," as defined in Section 125(e) of the Code.

Section 2.31 HIPAA means the Health Insurance Portability and Accountability Act of 1996, as codified in Section 9801, *et seq*., of the Code, and Section 701, *et seq*., of ERISA, as amended from time to time, and the applicable regulations issued and effective thereunder.

Section 2.32 HIPAA Enrollment Date means the effective date of the Employee's or Dependent's enrollment in the applicable HIPAA Program, or, if earlier, the first day of the waiting period for such enrollment.

Section 2.33 HIPAA Program means a Benefit Program subject to the portability and administrative simplification requirements of HIPAA, as required by Section 9801(f) of the Code.

Section 2.34 Insurance Company means an insurance company through which Benefit Program benefits are insured or which provides administrative services to a Benefit Program. For purposes of this definition, a health maintenance organization, exclusive provider organization or preferred provider organization may constitute an Insurance Company. Any insurance contract or certificate and any contract with such an organization maintained in connection with a Benefit Program will form part of the Plan and is incorporated herein by this reference.

Section 2.35 Leave of Absence means a period of employer-approved absence from service that is not treated as a termination of employment in accordance with the Employer's employment policies.

Section 2.36 Medicaid means Title XIX of the Social Security Act.

Section 2.37 Medicare means Part A, B or D of Title XVIII of the Social Security Act.

Section 2.38 Medical Care Expenses mean the expenses incurred for "medical care" as defined by Section 213(d)(1)(A) and (B) of the Code (excluding without limitation amounts paid for a long-term care insurance contract within the meaning of Section 7702B(b) of the Code) for the treatment of the Participant or his or her "eligible dependents", but which expenses are not payable under any group health, dental or vision care plan under which the individual receiving such treatment is covered. Medical Care Expenses will not include premiums for medical coverage, but may include deductibles and co-payments. For this purpose, "eligible dependents" will include a Participant's Spouse and any child (as defined in Section 152(f)(1) of the Code) of the Participant who as of the end of the taxable year, has not attained age 27.

Notwithstanding the foregoing, an expense for medicine or a drug shall be considered a Medical Care Expense only to the extent such medicine or drug (a) requires a prescription, (b) is available without a prescription and the individual obtains a prescription, or (c) is insulin. For these purposes, a "prescription" means a written or electronic order for medicine or a drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

Section 2.39 MHPAEA means the Mental Health Parity Act of 1996, as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, codified at Section 712 of ERISA and Section 9812 of the Code, as amended from time to time, and the applicable regulations issued and effective thereunder.

Section 2.40 Participant means (a) a current Employee who participates in a Benefit Program, or (b) a former Employee who is covered by a Benefit Program or is eligible to receive a benefit under a Benefit Program.

Section 2.41 Plan means the Hertz Custom Benefit Program, as set forth herein, together with any and all amendments, supplements and appendices hereto.

Section 2.42 Plan Year means the year, consisting of the 12 consecutive month period commencing on July 1 and ending on the next following June 30.

Section 2.43 Post-Service Claim means a Health Care Claim that is not a Pre-Service Claim, Urgent Care Claim or Concurrent Care Claim. For purposes of Section 7.05, all requests for reimbursement from a Participant's Health Care Spending Account, and for purposes of Section 9.04, all requests for reimbursement from a Health Reimbursement Account, will constitute Post-Service Claims.

Section 2.44 Pre-Existing Condition is any condition (physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended by a physician or received from a physician in the period provided by a Program Document.

Section 2.45 Pre-Service Claim means a Health Care Claim with respect to which the terms of a Benefit Program condition receipt of the benefit, in whole or in part, on approval of the

benefit in advance by the Administrator or Claims Administrator in advance of obtaining medical care.

Section 2.46 Program Document means the written description of the terms of each separate Benefit Program, including but not limited to a summary plan description, summary of material modifications, schedule of benefits, benefits booklet, or Insurance Company contract or certificate.

Section 2.47 Qualified Medical Child Support Order ("QMCSO") means a medical child support order that satisfies the requirements of the QMCSO procedures established by the Administrator.

Section 2.48 Qualified Reservist Distribution ("QRD") means a distribution to an individual of all or a portion of the balance in the individual's Health Care Spending Account if:

(a) The individual is a member of a reserve component ordered or called to active duty for a period of 180 days or more or for an indefinite period; and

(b) The request for a distribution is made during the period beginning on the date of the order or call to active duty and ending on the last day of the Plan Year that includes the date of the order or call to active duty.

Section 2.49 Section 152 Dependent means a Dependent who is defined as a dependent in Section 152 of the Code (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof for purposes of the Health Care Spending Account and any Benefit Program providing medical care). For purposes of Health Care Spending Accounts and any Benefit Program providing medical care, a child of a divorced Participant who would be a dependent (as defined in Section 152 of the Code) but for the fact that the divorce decree permits the Participant's former spouse to claim the child as a dependent for tax purposes will be considered a Section 152 Dependent of the Participant for purposes of the Plan.

Section 2.50 Spouse means a Participant's husband or wife who:

(a) has met all the requirements of a valid marriage contract in a jurisdiction which recognizes the marriage;

(b) meets the requirements of a spouse under federal tax law; and

(c) is covered by a Benefit Program.

Spouse does not include an individual who is legally separated from a Participant, unless recognized under the applicable Program Document or required by law. Where recognized by state law, the term "Spouse" will include common law spouses. For purposes of the Dependent Care Spending Account, "Spouse" will not include an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate principal residence during the last six months, and does not furnish more than one-half of the cost of maintaining the principal residence of the qualifying individual (as defined in Section 8.04(b)).

Section 2.51 State Child Health Plan has the meaning set forth under the State Children's Health Insurance Program established under Title XXI of the Social Security Act (or "CHIP").

Section 2.52 Third Party means any person or entity who is or may be liable for an injury, illness, disability, or death of a Covered Person including without limitation, an insurance company for such Third Party or a potentially liable person or entity; worker's compensation; homeowner's insurance; all coverages under an automobile policy of the Covered Person or a member of the Covered Person's family, including "no fault" coverage, medical coverage, and uninsured or underinsured motorist coverage; and other similar coverages. If appropriate under the circumstances, the Covered Person or any insurer of the Covered Person may be considered a Third Party if the Covered Person is or may be responsible for the injury, illness, disability or death of a Covered Person and/or the Covered Person has insurance coverage for such injury, illness, disability or death.

Section 2.53 TRICARE means the managed health care program established by the Department of Defense under Chapter 55 of Title 10, United States Code, for active duty and retired members of the uniformed services, their families, and survivors.

Section 2.54 Uniformed Service means the performance of duty on a voluntary or involuntary basis under competent authority, and includes active duty, inactive duty for training, initial active duty for training, full-time National Guard duty, and a period during which an Employee is absent from employment with an Employer for the purpose of an examination to determine the fitness of the Employee to perform any such duty in the United States 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 person designated by the President of the United States in time of war or emergency.

Section 2.55 Urgent Care Claim means a Health Care Claim for medical care not yet performed but, if delayed:

(a) could seriously jeopardize the Claimant's life, health, or the ability to regain maximum function; or

(b) in the opinion of a physician who has knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or medical treatment for which the Claimant is filing the claim.

Section 2.56 USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time, and the applicable regulations issued and effective thereunder.

ARTICLE III
ELIGIBILITY AND PARTICIPATION

Section 3.01 Eligibility to Participate. Except as specifically provided otherwise in an applicable Program Document or the Hertz Custom Benefit Program Eligibility Policy, each Benefit Program will cover all Employees who are regularly scheduled to work 30 or more hours per week; provided, however, that no former Employee or his or her Dependents will be covered by any Benefit Program unless such Benefit Program expressly covers the individual as a former Employee or as a Dependent of a former Employee, such as in the case of COBRA continuation coverage. Except as specifically provided otherwise in an applicable Program Document, in no event will an Employee be covered as both a Participant and Dependent, or a Dependent be covered as a Dependent of more than one Participant.

Except where otherwise provided in an applicable Benefit Program or as agreed upon in connection with a joint venture or acquisition, an Employee who is eligible to participate in a Benefit Program will become a Participant upon the later of:

(a) the first day of the month coinciding with or next following 60 days of employment, provided that the Employee appropriately and timely completed the enrollment application as determined by the Administrator;

(b) in the event that the Employee did not previously enroll, the date applicable under Section 5.01.

Notwithstanding the foregoing, to the extent specified in writing by the Board of Directors or the Committee, if a waiting period for a Benefit Program is waived for an Employee or a particular group of Employees with respect to a self-insured group health plan, then the Benefit Program (to the extent such waiting period is waived or different benefits are offered thereunder) will be treated as a "separate plan" within the meaning of the last sentence of Treasury Regulation Section 1.105-11(c)(4)(i).

Section 3.02 Participation Conditions. As a condition of participation and receipt of benefits under this Plan, each Participant will:

(a) timely submit an application to participate under the Plan to the Administrator in accordance with Article V;

(b) designate a portion of his Compensation, if any, as a Contribution to the Plan in accordance with Article IV and consent to have such amount withheld as a salary reduction contribution;

(c) observe all Plan rules and regulations;

(d) consent to the Administrator's inquiries with respect to any physician, hospital, or other medical care provider or other services involved in a determination for eligibility of coverage or a benefits claim under the Benefit Programs, or for reimbursement of Medical Care Expenses, Dependent Care Expenses or Adoption Expenses;

(e) submit to the Administrator all reports, bills, and other information that the Administrator may reasonably require, including but not limited to (i) information about Covered Persons necessary for compliance with the secondary payer reporting requirements under Medicare; and (ii) written substantiation by a third party of the amount of any Medical Care Expense, Dependent Care Expense or Adoption Expense to be reimbursed, and a written statement by the Participant that such expense is not reimbursable through other sources; and

(f) assure that any individual that he/she enrolls as a Dependent satisfies the definition to be considered as a Dependent under the applicable Benefit Program and provides such proof of eligibility as may be required by the Administrator.

Section 3.03 Termination of Participation.

(a) Except as otherwise specifically provided herein or in the applicable Program Document, coverage for a Participant under a Benefit Program will terminate when the earliest of the following events occurs:

(i) The Participant ceases to be an Employee of all Employers;

(ii) The Participant is no longer eligible to participate in the Plan;

(iii) The Participant fails to timely pay any required Participant contributions;

(iv) The Participant elects not to participate in a Benefit Program for the subsequent Plan Year during Annual Enrollment;

(v) The Company terminates the Benefit Program or amends the Benefit Program in a manner that it no longer applies to the Participant or Dependent;

(vi) The date the Participant commits fraud upon the Plan; or

(vii) 90 days after the Administrator requests repayment from the Participant (or any Dependent) of amounts that are subject to reimbursement under any Benefit Program, overpayments or mistaken payments from a Benefit Program, unless such Participant (or Dependent) repays such amounts or sets up a repayment schedule for same that is approved by the Administrator in its sole discretion.

(b) Coverage for a Participant's covered Dependent under a Benefit Program will terminate when the first of the following occurs:

(i) The Participant ceases to be covered; or

(ii) The covered Dependent is no longer an eligible Dependent.

Notwithstanding the foregoing, for purposes of the medical Benefit Program, dependent coverage will continue through the last day of the month in which the dependent turns 26.

(c) Except where otherwise provided in the applicable Program Document, in the event that coverage terminates upon one of the events identified above in this Section, such termination will be effective on the date that such event occurs. Notwithstanding the foregoing, for purposes of Section 3.03(a)(iii), if the Participant fails to make such premium payment within 30 days of the date the payment would otherwise be due, coverage shall terminate retroactive to the last date on which premiums were paid. Compensation reductions to pay for the cost of coverage will end effective for the period during which the loss of coverage occurred. Notwithstanding the foregoing, if a Participant and/or his covered Section 152 Dependent are eligible for and elect COBRA in accordance with Section 11.01, participation will terminate at the end of the applicable COBRA continuation coverage period.

Section 3.04 Termination of Employment. Notwithstanding any provision of the Plan to the contrary, a Participant who terminates employment with all Employers may, as applicable, receive benefits after such termination under Section 7.03, Section 8.03 or Article XI. To the extent that a Participant's termination constitutes a Change in Status, the Participant may modify or revoke his or her prior Plan elections in accordance with Section 5.06(a).

Section 3.05 Continuation of Participation During Leave of Absence. A Participant taking a paid or unpaid Leave of Absence may elect to continue to participate in the Plan using the benefit election that is in effect on the day immediately preceding the first day of such leave; provided, however, that to the extent that the Leave of Absence constitutes a Change in Status, the Participant may modify his or her Plan election as provided in Section 5.06(a). Notwithstanding the foregoing, a Participant will only be allowed to maintain coverage under the Plan while on an approved Leave of Absence if the Participant continues to have an employment relationship with an Employer, maintains his or her eligibility to participate in the applicable Benefit Program, and makes all required Participant contributions.

(a) Participating During Unpaid Leave of Absence. A Participant taking an unpaid Leave of Absence may continue his or her participation during such Leave of Absence for a period of up to 24 months; provided that the Participant may be required to make contributions towards the cost of participation during such Leave of Absence. Any required contributions shall be made in accordance with the requirements set forth in Treasury Regulation Section 1.125-3, Q&A-3.

(b) Participation During a Paid Leave of Absence. A Participant who is on a paid Leave of Absence may continue to participate in the Plan on the same basis as an active Employee, and his or her required contributions will be deducted from paychecks he or she receives during the paid Leave of Absence.

(c) USERRA. A Participant who is entitled to the protection of USERRA when taking a Leave of Absence to perform Uniformed Service will have the following additional rights:

(i) Uniformed Service for 30 Days or Less. If a Participant takes a Leave of Absence to perform Uniformed Service for a period of 30 days or less, the Participant will be treated as being actively at work during such Leave under Benefit Programs providing group health plan coverage (within the meaning of USERRA). During such period, the Participant will pay the

same amount, if any, that a Participant who does not take such Leave pays for such coverage.

(ii) Uniformed Service for 31 Days or More. If a Participant takes a Leave of Absence to perform Uniformed Service for a period of 31 days or more, the Participant may continue group health plan coverage under the applicable Benefit Programs for himself and each of his Covered Dependents. Such continued coverage will begin on the effective date of the Participant's Leave of Absence to perform Uniformed Service and end on the earliest of the following dates:

(A) the last day of the 24th month after the effective date of the Leave of Absence;

(B) the date the Participant fails to make a required USERRA contribution payment; or

(C) the date the Participant fails to return to or apply for a positon of reemployment within the applicable time frame set forth in USERRA.

A Participant who elects continued coverage while on such Leave will be required to pay the total amount of the cost of the coverage provided under the Benefit Program during the period of such Leave for the Participant and his Covered Dependents, as determined by the Administrator, plus 2%.

(iii) Relationship With COBRA. The USERRA continuation rights described above are independent of the Participant's right to elect COBRA continuation coverage. Notwithstanding the foregoing, if the Participant's Leave of Absence to perform Uniformed Service results in a loss of group health plan coverage, the Participant will be entitled to elect COBRA continuation coverage and if elected, COBRA continuation coverage will begin after the 30 day period described in subparagraph (i) ends. In all other respects, the Participant's COBRA continuation rights will run concurrently with the USERRA continuation rights.

(iv) Other Benefits. A Benefit Program that does not provide group health plan benefits will provide continuation coverage for Participants entitled to protection under USERRA to the same extent such coverage is made available to a Participant under the Employer's Leave of Absence policy that provides the most favorable continuation treatment under that Benefit Program.

(v) Reinstatement of Benefits. A Participant whose benefits have terminated during his Leave of Absence to perform Uniformed Service will be entitled to have such benefits reinstated upon his reemployment, to the extent provided under USERRA.

(d) FMLA. A Participant who takes a Leave of Absence under FMLA will continue to participate in his elected Benefit Programs while on such Leave as provided above under subsection (a) or (b). If premiums are changed while a Participant is on such Leave, the Participant will pay the new premium rates. If the Participant fails to timely pay the required cost of coverage in accordance with Department of Labor regulations issued under the FMLA, the Participant's coverage under the Benefit Programs may be terminated in accordance with such regulations.

(i) Employer's Right to Recoup Contributions. The Employer has the right to recover contributions it pays for maintaining group health plan coverage during a Participant's unpaid Leave of Absence under the FMLA when the Participant fails to return to work after such Leave ends. For purposes of the foregoing, a Participant who returns to work for at least 30 days is considered to have "returned" to work. The Employer will not have any such right, however, if the Participant's failure to return to work is due to:

(A) a serious health condition of the Participant or his family which would entitle the Participant to a Leave of Absence under the FMLA; or

(B) other circumstances beyond the Participant's control, such as the Participant's Spouse unexpectedly being transferred to a job location more than 75 miles from the Participant's work site, a relative or individual other than an immediate family member having a serious health condition and the Participant being needed to provide care, or the Participant being laid off while on leave. (Circumstances beyond the Participant's control do not include a mother deciding not to return to work to stay home with a newborn child or a Participant remaining in a distant location with a parent who no longer requires the Participant's care.)

(C) If a Participant does not return to work because of the reasons provided in subparagraph (1) or (2) above, the Employer may require medical certification of the Participant's or family member's serious health condition. If the Participant does not provide such certification within 30 days of the Employer's request the Employer may recover from the Participant group health plan contributions paid during the period of an unpaid Leave of Absence under the FMLA.

(ii) Relationship with COBRA. A qualifying event for purposes of COBRA continuation coverage occurs if, after the end of an unpaid Leave of Absence under the FMLA (as determined under Department of Labor regulations), a Participant does not return to work and, but for COBRA continuation coverage, that Participant would lose group health coverage. In such a case, the qualifying event will be deemed to have occurred on the last day of the Participant's Leave of Absence and the Participant may elect COBRA continuation coverage.

Section 3.06 Reinstatement of Former Participant.

(a) Rehires. Except as provided in Article VII, a Participant who terminates employment will be deemed to have revoked his or her election and terminated his or her receipt of benefits under this Article with respect to expenses incurred after the date of such employment termination.

(i) If a Participant who terminates employment is rehired within 30 days, however, the Participant's prior election will be automatically reinstated. With respect to the Health Care Spending Account, if a Participant is rehired within 30 days, the Participant will have access to the full amount designated by the Participant to be credited to such Account for that entire Plan Year, and the Participant will not be required to make up any contributions missed during the period of termination of employment.

(ii) If a Participant is rehired more than 30 days after termination of employment but less than 13 weeks after termination of employment, the rehired Employee will not be required to satisfy any service requirement prior to participating in the Plan and may make a new election in accordance with Article V provided he or she is still eligible. In addition, a rehired Employee may make an election that corresponds with the special enrollment rights set forth in Section 5.05. If the Participant is re-hired after 30 days but during the same Plan Year (and less than 13 weeks after termination of employment) and he or she does not make a new election within 30 days, his or her prior elections will be reinstated, except for his or her elections with respect to the Health Care Spending Account and Dependent Care Spending Account.

(iii) If a Participant is rehired 13 weeks or more after termination of employment, the rehired Employee will be treated as a new Employee for purposes of the Plan and will be required to satisfy any service requirement prior to participating in the Plan.

(iv) Notwithstanding the foregoing, if a Participant who terminates employment as part of a layoff is rehired within two years, such Employee will not be required to satisfy any service requirement prior to participating in the Plan and may make a new election in accordance with Article V provided he or she is still eligible.

(b) After FMLA Leave. Upon returning from FMLA leave, if coverage terminated while on FMLA leave (either by revocation or nonpayment of any required Participant contribution), the Employee may choose to prospectively reinstate his or her election for coverage under any group health plan (as defined in Section 5000(b)(1) of the Code), including the Health Care Spending Account. If the Employee does not elect to reinstate his or her election for coverage under any group health plan, the Employer may nevertheless require the Employee to resume participation if the Employer also requires Employees returning from unpaid non-FMLA leave to

resume participation upon return from leave. See Section 7.03(b) regarding reinstatement of coverage under the Health Care Spending Account after FMLA leave.

ARTICLE IV
BENEFIT CHOICES AND CONTRIBUTIONS

Section 4.01 Participant Contributions Required for Plan Coverage. The Employer will determine whether any of the Benefit Programs will require Participants to contribute toward the cost of coverage. Any Benefit Programs which do require Participant contributions will be designated as optional Benefit Programs. The Employer will establish the cost of coverage applicable to Participants under the optional Benefit Programs, may adjust such costs from time to time, and will determine whether such costs are to be paid by the Participants on a pre-tax or an after-tax basis. A Participant who is an Employee will be required to contribute such cost of coverage under the optional Benefit Programs elected under the Plan by automatic reduction of the Participant's Compensation on a pre-tax or after-tax basis, as applicable. Compensation reductions to pay for the cost of coverage will begin effective as of the coverage date. The Administrator will track the Participant contributions and apply them toward the cost of coverage of the optional Benefit Program.

Section 4.02 Benefit Program Choices. Benefit Programs which do not require Participant contributions will be automatically available to Employees who are eligible under the terms of the applicable Benefit Program. An eligible Employee may also elect under this Plan to obtain coverage under the optional Benefit Programs for which he or she is eligible in accordance with the procedures described in Article V. If such Employee so elects, a portion of his or her Compensation will be applied by the Employer on a pre-tax or after-tax basis (as the case may be) to satisfy the Employee cost of such optional Benefit Programs. While a Participant's election to receive and pay for certain benefits may be made under this Plan, the benefits will be provided pursuant to the applicable underlying Program Documents.

ARTICLE V
ENROLLMENT AND ELECTIONS

Section 5.01 Initial Enrollment. Each Employee who becomes eligible to participate in an optional Benefit Program pursuant to Section 3.01 of the Plan will be furnished with enrollment materials and given the opportunity to elect to participate.

(a) Mid-Year Enrollment. Any individual who was not eligible to participate as of the first day of a Plan Year but who becomes eligible to participate in the Plan during that Plan Year may elect to participate in the Plan. Such individual must file with the Administrator a completed Election Form within 31 days after the date the Employee becoming eligible to participate in the Plan (after receiving a written description of the available Benefit Programs). If such an individual fails to file a completed Election Form within 31 days, such individual will be treated as waiving his or her right to participate in the optional Benefit Programs under the Plan for the remainder of such Plan Year, subject to Section 5.05.

Mid-year enrollment under this Section will become effective on the first day of the month coinciding with or next following the election, assuming the Participant files a completed Election Form within 31 days of the date the Participant would otherwise be eligible to enroll, except where agreed upon in connection with a joint venture or acquisition. Notwithstanding the foregoing, if an individual becomes eligible to participate due to a change in status to full-time employment, his or her enrollment will become effective on the first day of the month coinciding with or next following the change in status to full-time employment, assuming the Participant files a completed Election Form within 31 days of the date the Participant became eligible to enroll. Compensation reductions to pay for the cost of coverage elected under this Section will begin for the period coinciding with or next following the effective date of mid-year enrollment.

(b) Initial Enrollment for Subsequent Plan Years. Any Employee who is eligible to participate but who previously waived or revoked participation may commence participation in the Plan as of the start of a subsequent Plan Year by filing with the Administrator, within the designated enrollment period, a completed Election Form by which the Employee elects to participate in one or more of the optional Benefit Programs for such Plan Year pursuant to Section 5.02. Any election made under this Section will be subject to the terms of the underlying Program Document.

Section 5.02 Annual Enrollment. Before the first day of each Plan Year, each Employee who is eligible to participate in the Plan as of the start of the next upcoming Plan Year and each Employee on FMLA leave will be furnished with an Election Form and given the opportunity to elect to participate in the optional Benefit Programs for that next Plan Year. (An Employee's entitlement to a Benefit Program other than a group health benefit while on FMLA leave will be determined by the Employer's policies for providing such benefits while an Employee is on a non-FMLA leave.) A current description of the Benefit Programs for which the Employee would be eligible if he or she elected to participate will also be furnished to the Participant before or at the start of the election period. To be valid, the Election Form must be completed and returned to the

Administrator on or before the end of the designated election period for the Plan Year to which it applies.

(a) On the Election Form, the Employee will designate the optional Benefit Programs in which he or she elects to participate for the applicable Plan Year as well as the applicable level of coverage under such Benefit Program and the identity of any Dependents to be covered.

(b) The Election Form will take effect as of the first day of such Plan Year and will remain in effect throughout the Plan Year unless modified or revoked in accordance with Section 5.05 or 5.06. Each Participant's Election Form will be valid for one Plan Year and must be renewed from Plan Year to Plan Year subject to Section 5.04(b).

Section 5.03 Election Forms. Elections and revocations of elections will be made on such forms, including telephonic or electronic media, and in accordance with such rules as may be provided or established from time to time by the Administrator. The Administrator will make Election Forms available to Employees or Participants (a) upon request, (b) within a reasonable time following an Employee's date of hire and before an Employee becomes a Participant, and (c) within a reasonable time before the beginning of each Plan Year.

Section 5.04 Failure to Return Election Form.

(a) Initial Election. If an Employee fails to return a completed election form to the Administrator on or before the specified due date for the initial Plan Year, that failure will constitute an election not to participate in the optional Benefit Programs and an election to receive the Employee's full Compensation in cash, except that the Administrator reserves the right to select a default enrollment option and deem the Employee to have elected coverage in that default option.

(b) Automatic Renewals. A Participant's failure to return a completed Election Form to the Administrator on or before the specified due date for any subsequent Plan Year will constitute (i) a re-election of the same Benefit Program benefits and coverage, if any, as were in effect for the Participant immediately before the end of the preceding Plan Year, except for the Health Care Spending Account and Dependent Care Spending Account; (ii) an agreement to reduce the Participant's Compensation for the subsequent Plan Year in an amount equal to the Participant's share of the cost during such Plan Year of the relevant optional Benefit Programs and coverages; and (iii) an election to not participate in the Health Care Spending Account and Dependent Care Spending Account for the upcoming Plan Year. For any subsequent Plan Year in which the Administrator requires affirmative enrollment (if applicable and as communicated in enrollment materials), failure to return an Election Form shall constitute either an election not to participate in the Plan or, if specified in applicable enrolment materials, a default election for particular Benefit Programs under the Plan. Any Participant who does not desire the same Benefit Program benefits and coverage for the next Plan Year or who wishes to enroll in the Health Care Spending Account or Dependent Care Spending Account must, on or before the end of the designated election period, file with the Administrator a completed Election Form with respect to the upcoming Plan Year. The Administrator reserves the right to conduct an affirmative enrollment when it sees fit, in its sole discretion.

Section 5.05 Special Enrollment Rules. Notwithstanding anything contained herein to the contrary, if an Employee does not timely enroll in a HIPAA Program when such program would otherwise permit the Employee to enroll himself or herself (and/or his or her eligible Dependents) and the Employee subsequently wishes to elect such coverage, the Employee may do so in appropriate circumstances under these special enrollment rules.

(a) Loss of Coverage. An Employee may enroll for health coverage under a HIPAA Program for the Employee and his or her eligible Dependents if

(i) the Employee (and, if applicable, his or her eligible Dependents) is eligible for health coverage under that program but is not currently enrolled;

(ii) the Employee declined health coverage under that program when it was offered previously and gave the existence of alternative health coverage as the reason for waiving such coverage on the Employee's health Benefit Program enrollment form; and

(iii) the alternative coverage has terminated, because either

(A) it was COBRA continuation coverage that has been exhausted (this does not include COBRA coverage that terminates because of failure to pay contributions or for cause), or

(B) eligibility for the alternative coverage was lost, including but not limited to, as a result of

(1) legal separation,

(2) divorce,

(3) death,

(4) termination of employment,

(5) reduction in the number of hours of employment,

(6) an individual ceasing to reside, live, or work in an HMO service area (whether or not within the choice of the individual), in the case of coverage under an HMO (or other arrangement) that does not provide benefits to individuals who cease to reside, live or work in the service area,

(7) an individual meeting or exceeding a lifetime limit on benefits,

(8) cessation of Section 152 Dependent status,

(9) the plan no longer offering benefits to the class of similarly situated individuals that includes the individual, or

(10) for reasons other than the individual's failure to pay contributions or for cause, as provided in applicable regulations, or

(C) employer contributions toward the cost of the coverage terminated,

(D) notwithstanding anything in the Plan to the contrary, if the alternative coverage was under a Medicaid plan or under a State Child Health Plan, and the Participant or Section 152 Dependent lost eligibility for such coverage, provided that the Participant requests coverage under the Plan not later than 60 days after the date of termination of such alternative coverage.

In this case, the Employee must submit a completed Election Form within 31 days after the date on which (i) COBRA continuation coverage was exhausted, or (ii) the coverage terminated because of loss of eligibility for coverage or the termination of employer contributions toward the cost of the coverage. Enrollment in a HIPAA Program pursuant to this paragraph will be effective as of the date Employee submits a completed Election Form, provided the Administrator receives a completed Election Form within 31 days of the relevant event.

(b) New Dependent. In addition, an Employee may enroll for health coverage under a HIPAA Program for the Employee and his or her eligible Section 152 Dependents if (i) the Employee is eligible for health coverage under that program but is not currently enrolled, or is currently enrolled but his or her new Section 152 Dependent is not currently enrolled; and (ii) another individual (a Spouse or child) has become a Section 152 Dependent of the Employee through marriage, birth, adoption, or placement for adoption.

In this case, the Employee must submit a completed Election Form within 31 days of the marriage, birth, adoption, or placement for adoption unless a Benefit Program allows a longer period of time. Enrollment in a HIPAA Program pursuant to this section (except in the case of marriage) will be effective as of the date of the event, provided the Administrator receives the completed Election Form within 31 days of the event. In the case of the Employee's marriage, the enrollment will be effective the first of the month following the event, provided the Administrator receives the timely completed Election Form.

If the Employee does not notify the Administrator within 31 days of the birth of a new eligible dependent, the Employee may not add the new eligible Section 152 Dependent to his coverage until the next open annual enrollment period or the next time a special enrollment rule is triggered.

(c) Eligibility for State Assistance. Notwithstanding anything in the Plan to the contrary, an Employee may also enroll in health coverage under a HIPAA Program for the Employee and his or her eligible Section 152 Dependents if the Employee or Section 152 Dependent (i) becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a State Child Health Plan with respect to coverage under the Plan, or (ii) is covered under

a plan offered under Medicaid or a State Child Health Plan and such coverage is terminated as the result of a loss of eligibility; provided that the Employee requests coverage under the Plan not later than 60 days after the date the Employee or Section 152 Dependent is determined to be eligible for such assistance. Such coverage will be effective as of the first day of the month immediately following the completed election.

Section 5.06 Modifying and Revoking Elections. Except as provided in this Section 5.06, a Participant's election made under this Article will be irrevocable after it is filed with the Administrator; provided, however, that if a Participant fails to make required contributions, his or her election will be deemed to have been revoked, and benefits will cease.

(a) Change in Status. An Employee may revoke his or her election for the Plan Year and make a new election with respect to adding or dropping coverage if he or she experiences a Change in Status and the election change is consistent with the Change in Status. An Employee may not use the Change in Status to switch between providers, programs or plans unless the change is consistent with the Change in Status. An election change must be on account of, and correspond with, a Change in Status that affects eligibility for coverage under said Benefit Program. With respect to an Employee's election to contribute to a Dependent Care Spending Account, an election change may be made where a Change in Status affects Dependent Care Expenses. The Administrator (in its sole discretion) will determine based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status.

(b) QMCSOs. The Administrator will be permitted to modify an Employee's election to provide coverage under an accident or health plan for a child or foster child who is a dependent of the Employee if a judgment decree or order resulting from divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires coverage for the child. An Employee will be permitted to revoke his or her election for the Plan Year and make a new election to provide for or cancel coverage for the child if the order requires the Spouse, former Spouse or other individual to provide coverage for the child. The Administrator, in its sole discretion, will determine whether the order qualifies as a QMCSO in accordance with procedures established for such purpose. The Employee's new election will take effect as of the effective date provided in the QMCSO Procedures established by the Administrator.

(c) Medicare or Medicaid Entitlement. If an Employee or his or her Section 152 Dependent receiving coverage under a Benefit Program becomes enrolled for coverage under Medicare or Medicaid (other than coverage under a program solely providing pediatric vaccinations), the Employee may cancel or reduce coverage prospectively for that individual under an accident or health plan. In addition, if an Employee or Section 152 Dependent becomes ineligible for Medicare or Medicaid coverage, the Employee may prospectively make a new election to commence or increase coverage for that individual under an accident or health plan.

(d) Change in Cost. *The following rules are not applicable to a Health Care Spending Account under the Plan.* For purposes of this Section 5.06(d), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, a medical care spending account (MSA) is not similar coverage with respect to a health plan that is not an MSA; an HMO and PPO are considered to be similar

coverage; and coverage by another employer, such as a Spouse's or Section 152 Dependent's employer, is treated as similar coverage

(i) Insignificant Cost Changes. Participants are required to increase their elective contributions to reflect insignificant increases in their required contribution for elected Benefit Programs, and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including, but not limited to, the dollar amount or percentage of the cost change. The Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected Employees' elective contributions on a prospective basis.

(ii) Significant Cost Increases. If the Administrator determines that the cost charged to an Employee of a Participant's Benefit Program option significantly increases during a Plan Year, the Participant may (a) make a corresponding prospective increase in his or her elective contributions; (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another option available and offered under the Benefit Program that provides similar coverage; or (c) revoke his or her election and drop coverage prospectively if there is no other coverage option available that provides similar coverage. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(iii) Significant Cost Decreases. If the Administrator determines that the cost of any Benefit Program option significantly decreases during a Plan Year, the Administrator may permit the following election changes: (a) Participants who are enrolled in a coverage option may change their election on a prospective basis to elect the Benefit Program option that has decreased in cost; and (b) Employees who are otherwise eligible may elect the Benefit Program option that has decreased in cost on a prospective basis; subject to the terms and limitations of the Benefit Program option. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(e) Change in Coverage. *The following rules are not applicable to a Health Care Spending Account under the Plan.* The definition of "similar coverage" under Section 5.06(d) applies also to this Section 5.06(e).

(i) Significant Curtailment. If coverage is "significantly curtailed" (as defined in subsection (A) below), Participants may elect coverage under another Benefit Program option that provides similar coverage. In addition, as set forth in subsection (B) below, if the coverage curtailment results in a "Loss

of Coverage" (as defined in subsection (C) below), Participants may drop coverage if no similar coverage is offered. The Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(A) Significant Curtailment Without Loss of Coverage. If the Administrator determines that a Participant's coverage under a Benefit Program option under this Plan (or the Participant's Spouse's or Section 152 Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage during a Plan Year, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Program option that provides similar coverage. Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(B) Significant Curtailment With a Loss of Coverage. If the Administrator determines that a Participant's Benefit Program option coverage under this Plan (or the Participant's Spouse's or Section 152 Dependent's coverage under his or her employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Plan Year, the Participant may revoke his or her election for the affected coverage, and may either prospectively elect coverage under another Benefit Program option that provides similar coverage, or drop coverage if no other Benefit Program option providing similar coverage is offered.

(C) Definition of Loss of Coverage. For purposes of this Section 5.06(e)(i)(C), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Program option, an HMO ceasing to be available where the Participant or his or her Spouse or Section 152 Dependent resides, or a Participant or his or her Spouse or Section 152 Dependent losing all coverage under the Benefit Program option by reason of an overall lifetime or annual limitation). In addition, the Administrator in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under a health plan coverage option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in a PPO or an HMO);

- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Section 152 Dependent is currently in a course of treatment; or

- any other similar fundamental loss of coverage.

(ii) Addition or Significant Improvement of a Health Plan Option. If during a Plan Year, a new Benefit Program option is added or an existing Benefit Program option is significantly improved, the Administrator may permit an election change to salary reductions if: (1) Participants who are enrolled in a Benefit Program option other than the newly-added or significantly improved Benefit Program option change their election on a prospective basis to elect the newly-added or significantly improved Benefit Program option; and (2) Employees who are otherwise eligible elect the newly-added or significantly improved Benefit Program option on a prospective basis; subject to the terms and limitations of the Benefit Program option. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Program option in accordance with prevailing IRS guidance.

(iii) Loss of Coverage Under Other Group Health Coverage. A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Section 152 Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a State Child Health Plan; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Program option(s).

(iv) Change in Coverage Under Another Employer Plan. A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Section 152 Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Plan Year that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of

and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

(f) Loss of Governmental or Educational Institution Sponsored Coverage. An Employee may make an election to participate in a Benefit Program if the Employee or his or her Section 152 Dependent loses coverage under any group health program sponsored by a governmental or educational institution.

(g) Unpaid FMLA Leave. An Employee taking an unpaid FMLA leave may revoke an existing election for the remaining portion of the Plan Year. Employees on unpaid FMLA leave will have the right to enroll in the Plan or change their election while they are on leave in the same manner as active Employees, rather than having to wait until returning to work. These rights will be in addition to any right to change an election under paragraphs (a) through (f) above. See Sections 3.06(b), 7.03(b) and 8.03(b) for special rules that apply to unpaid FMLA leave.

(h) COBRA. If an Employee or his Covered Dependent becomes eligible for COBRA continuation coverage under the Plan and the Employee continues to receive Compensation, he may elect to increase his Contributions under the Plan to pay for the COBRA continuation coverage.

(i) HIPAA Special Enrollment Rights. An Employee who acquires special enrollment rights under HIPAA may revoke his previous Benefit Program elections for the Plan Year and make a new election that corresponds with such enrollment rights, regardless of whether the HIPAA special enrollment also qualifies as a Change in Status. The Employee's new benefit election will take effect on the date that coverage for the special enrollment is effective under HIPAA.

(j) Changes Related to Affordable Care Act Coverage. An Employee may revoke his or her previous Benefit Program election for the remainder of the Plan Year if:

(i) Reduction in Hours of Service. The Employee, who had been reasonably expected to average at least 30 hours of service per week, experiences a change in his or her employment status such that he or she is reasonably expected to average less than 30 hours of service per week after the change, even if that reduction does not result in his or her ceasing to be eligible under the applicable Benefit Program; provided that revocation of the election of coverage under the Benefit Program corresponds to the intended enrollment of the Employee (and any related Dependents who also cease coverage due to the revocation) in another plan that provides Minimum Essential Coverage, with the new coverage effective no later than the first day of the second month following the month that includes the date the coverage under the Benefit Program is revoked.

(ii) Enrollment in Qualified Health Plan. The Employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Employee seeks to enroll

in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; provided that revocation of the election of coverage under the Benefit Program corresponds to the intended enrollment of the Employee (and any related Dependents who also cease coverage due to the revocation) in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of coverage under the Benefit Program. Notwithstanding anything to the contrary in Section 5.06(j) an Employee's election changes pursuant to this Section 5.06(j)(i)(ii) will be effective as of the date immediately before the first date of coverage under the Qualified Health Plan.

For purposes of this Section 5.06(j), the term Benefit Program shall only include "group health plan" coverage (i.e., an employee welfare benefit plan within the meaning of Section 3(1) on ERISA to the extent that such plan provides medical care within the meaning of Section 733(a) of ERISA). Election changes under this Section 5.06(j) shall only be permitted to the extent such changes (including the termination of coverage under this Benefit Program) are consistent with IRS Notice 2014-55 and any subsequent regulations. Capitalized terms used in this Section 5.06(j) but not otherwise defined shall have the same meaning as in IRS Notice 2014-55.

(k) Domestic Partners. If a Domestic Partner is not a Section 152 Dependent, then group health coverage for the Domestic Partner is not provided under the Cafeteria Program. Nonetheless, benefit changes corresponding to the commencement or termination of a domestic partnership will be limited to those instances described herein for benefit changes corresponding to marriage or divorce.

(l) Procedure for Modifying Election. An Employee will make election changes under this Article by filing a new Election Form with the Administrator within 31 days (or such longer time as the Administrator may allow) after the date of the applicable event described in the applicable subsection.

(m) Effective Date of Modified Election. Except as provided below, an Employee's election changes pursuant to this Section 5.06 and new contribution levels will become effective the date Employee submits a completed Election Form with the Administrator.

(n) Becoming Ineligible. Upon the Administrator receiving notice that an Employee, Spouse or Dependent has lost eligibility under an underlying plan, the Administrator will automatically change the Participant's election either retroactively, as of the date the individual becomes ineligible for coverage in which case the Employee's contributions attributable to such coverage will be refunded to the Employee and any benefits paid recouped, or prospectively.

(o) Other Events. In the sole discretion of the Administrator, an Employee may be permitted to revoke or change an election upon any other event recognized for purposes of changing Plan elections under applicable law and regulations.

Section 5.07 Nondiscrimination Requirements.

(a) The Administrator may periodically conduct such testing as it deems necessary to comply with the nondiscrimination requirements under Sections 79, 105(h), 125, 129, 137 and 9815 of the Code. The Administrator has the right to adjust any Participant's Compensation reduction election made under this Article at any time and from time to time (i) to ensure that the Plan complies with any applicable nondiscrimination requirements of the Code referenced above, and (ii) to rectify erroneous Compensation reductions, contributions and credits.

(b) The Plan will not provide any statutory non-taxable benefits in a Plan Year to key employees (as defined in Section 416(i)(1) of the Code) in excess of 25 percent of the aggregate of such benefits provided to all Employees under the Plan. For purposes of the preceding sentence, qualified benefits will not include benefits which (without regard to this Section) are includable in the Participant's gross income.

(c) For purposes of this Section, statutory non-taxable benefits include qualified benefits (as defined in Section 125(f) of the Code and applicable regulations) that are excluded from income. Statutory non-taxable benefits also include group-term life insurance on the life of an Employee includable in the Employee's gross income solely because the coverage exceeds the limit in Section 79(a) of the Code.

ARTICLE VI
FUNDING AND ACCOUNTS

Section 6.01 Funding, Trust Agreements, and Insurance.

(a) The Benefit Programs may be funded through the use of trusts (including, where applicable, one or more trusts meeting the requirements of Section 501(c)(9) of the Code), Insurance Company contracts, or otherwise, in accordance with the various documents forming part of the Plan and the respective Benefit Programs. The benefits provided by the Benefit Programs will be supported by the contributions of the Employer, Participants and covered Dependents, as the case may be, in accordance with the Program Documents for the respective Benefit Programs. To the extent that a trust agreement or insurance contract funds part or all of the benefits provided by a particular Benefit Program, such agreement or contract will be deemed part of the Plan and incorporated herein by this reference.

(b) An Employer will have the right to enter into a contract with one or more Insurance Companies for the purposes of providing any benefits under the Plan and to replace any of such Insurance Companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type which may become payable under any such insurance contract will not be assets of the Plan but will be the property of, and will be retained by, the Employer to the extent permitted by law. In the event that amounts are attributable to employee contributions or are required to be treated as Plan assets by law, the Administrator will make a reasonable determination as to how to apply such refunds. The Employer will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this Plan, including, but not be limited to, losses or obligations which pertain to the following:

(i) Once insurance is applied for or obtained, an Employer will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Employer.

(ii) To the extent premium notices are received by an Employer, the Employer's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other loss which results from such failure.

(iii) An Employer will not be liable for the payment of any insurance premium or any loss which may result from the failure to pay an insurance premium if Participant contributions (if any) are not enough to provide for such premium cost at the time it is due. In such circumstances, the Employee will be responsible for and see to the payment of such premiums. The Employer will undertake to notify a Participant if Participant contributions under this Plan are not enough to provide for an insurance premium and that such policy will terminate if the Participants do not see to the payment of such premiums, but will not be liable for any failure to make such notification.

(iv) When employment ends, an Employer will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this Plan, and an Employer will not be liable for or responsible to see to the payment of any premium after employment ends.

Section 6.02 Benefits Supported Only by Benefit Program. Any person having any claim under a Benefit Program will look solely to the assets of the Benefit Program, if any, for satisfaction. In no event will the Employer, any officers or agents thereof, or any member of the Board of Directors or other governing body be liable to any person under the provisions of the Benefit Program.

Section 6.03 Rights of Participants. No Participant will have any right to any amount credited to his or her Account at any time, except as follows:

(a) the right to have such credits applied toward the cost of coverage for his or her Benefit Program in accordance with this Plan; and

(b) the right to have any excess amounts which were deducted from his or her Compensation and credited to his or her Account by mistake of the Administrator restored to him or her as though part of Compensation. Such restoration will be made only if: (i) the Participant so requests in writing received by Administrator within one year after the mistaken credit was made; and (ii) the mistaken amount has not already been applied toward the cost of coverage for his or her elected Benefit Program. If such restoration cannot be made solely due to clause (ii), then the Employer may adjust the Participant's future Compensation reductions under the Plan to rectify the prior mistake. No interest will accrue or be owed to any Participant with respect to any restoration of Compensation under this Section.

ARTICLE VII
HEALTH CARE SPENDING ACCOUNT

Section 7.01 Type of Benefit. Pursuant to Article V, a Participant may elect to contribute a portion of his or her Compensation to a Health Care Spending Account on a pre-tax basis. The amounts contributed to the Health Care Spending Account are then used to reimburse the Participant for Medical Care Expenses. The Health Care Spending Account is intended to be a self-insured medical reimbursement plan within the meaning of Section 105(h) of the Code and a flexible spending arrangement within the meaning of Proposed Treasury Regulation Section 1.125-5, or subsequent guidance. The Employers and the Administrator will take whatever steps necessary to maintain and operate the Health Care Spending Account in accordance with the nondiscrimination requirements of Sections 105(h) and 125 of the Code.

Section 7.02 Maximum Contribution. The minimum (if any) and maximum amounts a Participant may elect to contribute to a Health Care Spending Account will be determined by the Company each year and communicated to Participants in the annual enrollment materials; provided, however, that in no event will such amount exceed $2,700 (as adjusted for inflation in accordance with the rules of Section 125(i)(2) of the Code).

Section 7.03 Benefits After Termination and Reinstatement After Return.

(a) A Participant in the Health Care Spending Account who terminates employment and who does not elect continuation coverage as provided for herein, will be deemed to have revoked his or her participation under the Health Care Spending Account. Such former Employee will continue to be eligible to claim reimbursement for expenses incurred before the effective date of the former Employee's termination of employment or, if later, the end of the period of coverage for which the last contribution has been made. A Participant in the Health Care Spending Account who goes on a Leave of Absence will be deemed to have continued participation in the Health Care Spending Account unless he or she elects otherwise. In such event, the Employee will continue to be eligible to claim reimbursement for expenses incurred before the effective date of the Employee's Leave of Absence.

(b) In the event an Employee does not have coverage under the Health Care Spending Account during FMLA leave (because the Employee chooses to revoke coverage or does not pay the required employee contributions for any reason during FMLA leave), upon returning from FMLA leave, the Employer will reinstate the Participant's Health Care Spending Account coverage. Upon reinstatement of coverage, the Participant may choose to:

(i) reinstate his per pay period deduction under the Health Care Spending Account, in which case the Participant's elected annual Participant Contributions will be prorated for the period during which no contributions were paid, and reduced by prior reimbursements; or

(ii) resume Participant Contributions at the same annual contribution level, in which case the Participant's per pay period deduction under the Health Care Spending Account will be adjusted to an amount equal to the annual Participant Contributions less the actual Participant Contributions, divided

by the number of pay periods remaining in the Plan Year. Notwithstanding the preceding provisions of this subparagraph (ii), if the Plan has already made disbursements to the Participant that exceed the Participant Contributions that will be paid for the Plan Year, the Employer may not require the Employee to pay any more than the remaining Participant Contributions due.

In no event will reimbursements be permitted for any otherwise eligible medical care expenses during such Leave.

(c) If the Health Care Spending Account coverage continues during the FMLA leave, the Participant's contributions will continue as though he or she is not on a Leave of Absence.

Section 7.04 Medical Care Expenses. Each Participant will be entitled to reimbursement from his or her Health Care Spending Account for Medical Care Expenses incurred during a Plan Year and related Grace Period.

Section 7.05 Claim and Payment Procedures. The entire amount a Participant elects to contribute to his or her Health Care Spending Account for the year, less any reimbursements made from the Account for the year, will be available at all times during the period of coverage. A Participant must file claims for reimbursement of Medical Care Expenses from his or her Health Care Spending Account to the Claims Administrator in the manner prescribed by the Claims Administrator. Properly submitted claims will be paid monthly or when the total amount of the claims submitted is at least the minimum amount specified by the Administrator. Claims will be honored only if:

(a) incurred for Medical Care Expenses of the Participant or his or her eligible dependent;

(b) incurred for treatment rendered while the recipient was covered by the Health Care Spending Account; and

(c) substantiated by (A) a written statement from an independent third party (such as the service provider) stating that the expense was incurred, identifying the treatment or service provided, the date of service, and the amount of the expense; and (B) a written statement from the Participant that the expense has not been reimbursed and is not reimbursable from any other source of coverage. If an explanation of benefits is submitted indicating the date of the service and the amount the Participant is responsible to pay, together with the statement described in (B) above, the claim will be deemed fully substantiated.

For this purpose, a Participant or eligible dependent has incurred a Medical Care Expense when he or she receives the medical care that gives rise to the Medical Care Expense, regardless of when the Participant or his or her eligible dependent is formally billed or charged for, or pays the Medical Care Expense.

Payments pursuant to this Section will be made only to Participants, and no payment will be made directly to the provider of the medical care services, treatment or supplies.

Expenses incurred during a Plan Year's related Grace Period will be reimbursed from a Participant's Health Care Spending Account for such Plan Year, pursuant to this Section 7.05, so long as funds remain in the Participant's Health Care Spending Account for such Plan Year. After a Participant's Health Care Spending Account for such Plan Year has been exhausted, expenses incurred during the Grace Period may be reimbursed from the Participant's Health Care Spending Account for the Plan Year containing the Grace Period, if applicable, subject to the requirements set forth in this Section 7.05.

Section 7.06 Electronic Card Reimbursement. The Administrator may make available a credit or debit card (within the meaning of Proposed Treasury Regulation Section 1.125-6(b)(6), or subsequent guidance) to enable Participants to pay for eligible Medical Care Expenses under the Plan at the point of purchase. In addition to the requirements generally applicable to Health Care Spending Accounts under the Plan, credit or debit cards issued under the Plan will be subject to the following:

(a) Participant Certification. Each Participant who is issued a credit or debit card under the Plan will certify upon enrollment in the Plan and each Plan Year thereafter, that: (i) the credit or debit card will only be used to pay for eligible Medical Care Expenses for the Participant and/or the Participant's Dependent, (ii) the eligible Medical Care Expenses paid with the card have not been reimbursed and that the Participant will not seek reimbursement under any other plan covering health benefits, and (iii) sufficient documentation (including invoices and receipts) for any expense paid with the card will be acquired and retained. The Participant's certification will be deemed to be reaffirmed each time the card is used.

(b) Substantiation. All Medical Care Expenses paid or reimbursed through the use of a credit or debit card will be substantiated in accordance with the requirements and guidance issued by the Internal Revenue Service. To provide assurance that only eligible Medical Care Expenses are reimbursed, the following procedures for substantiating claimed medical expenses after the use of the card will apply:

(i) Multiples of Five or Fewer: If the dollar amount of the transaction at a medical care provider equals an exact multiple of not more than five times the dollar amount of any co-payment (or exact matches or multiples or combinations of different co-payments for the same benefit, but not more than the exact multiple of five times the maximum copayment) for that service under the HIPAA health plan, the charge will be deemed to be fully substantiated without the need for submission of a receipt or further review.

(ii) Recurring Expenses: Recurring expenses that match expenses previously approved as to amount, provider and time period (*e.g.*, for a Participant who refills a prescription drug on a regular basis at the same provider for the same amount) may be reimbursed without further substantiation.

(iii) Real-Time Substantiation: If the merchant, service provider, or other independent third-party, at the time and point of sale, provides information to verify (including electronically by e-mail, the internet, intranet or telephone) that the charge is for an eligible Medical Care Expense, the

charge will be deemed to be fully substantiated without the need for submission of a receipt or further review.

(iv) Inventory Information Approval System: If the merchant uses a system that compares inventory control information with a list of items that qualify as medical care under Section 213(d) of the Code (including over-the-counter medications as described in Rev. Rul. 2013-102) and the merchant's system approves the use of the card for the expense, then the charge will be deemed to be substantiated in the amount approved by the merchant.

(v) Other: All charges to the card, other than exact multiples of not more than five times co-payments, recurring expenses, real-time substantiation, inventory control approval, or third-party substantiation as described above, will be treated as conditional pending confirmation of the charge.

(c) Amount of Coverage. A Participant's use of a credit or debit card will be limited to the amount credited to such Participant's Health Care Spending Account. Any Medical Care Expense incurred in excess of such amount will not be paid by the Plan. Merchants or service providers accepting the credit or debit card issued under the Plan will be paid the full amount of the charge, subject to the Participant's Health Care Spending Account balance, and such Participant's Health Care Spending Account balance will be reduced by the corresponding amount.

(d) Scope of Use. Participants issued a credit or debit card under the Plan will only be permitted to use it at merchants or service providers authorized by the Plan, and use of such card will be limited to: (i) physicians, dentists, vision care offices and hospitals and other medical care providers (as identified by the merchant category code); (ii) stores with the merchant category code for Drug Stores and Pharmacies if, on a location by location basis, 90% of the store's gross receipts during the prior taxable year consisted of items which qualify as Medical Care Expenses; and (iii) stores that have implemented an inventory information approval system that operates in accordance with applicable regulations and other guidance issued by the Internal Revenue Service.

(e) No Card Requirement. Notwithstanding anything herein to the contrary, a Participant will not be required to use or obtain a credit or debit card to obtain benefits under the Plan.

(f) Other Requirements. The Administrator is authorized to adopt, from time to time, such other reasonable administrative procedures and requirements as may reasonably be deemed necessary or appropriate to facilitate the credit or debit card program under the Plan, provided such procedures and requirements are not materially inconsistent with the terms of the Plan and applicable law. All such procedures and requirements are hereby fully incorporated into, and will be deemed to be an integral part of, the Plan.

Section 7.07 Forfeitures; Use It or Lose It Rule.

(a) Use It or Lose It Rule. Claims received by the Administrator after the December 31 deadline immediately following the close of the prior Plan Year for expenses incurred during that closed Plan Year and its related Grace Period will be untimely and not eligible for reimbursement under the Plan; however, expenses incurred during the Grace Period may be

reimbursable during the then current Plan Year. A Participant or former Participant will not be entitled to receive cash or any other form of compensation or benefits with respect to any unused balance in his or her Health Care Spending Account after all timely claims have been processed as of the end of a Plan Year. Similarly, no balance remaining after the expiration of the period for submitting claims for a Plan Year will be carried forward into any succeeding Plan Year.

(b) Use of Forfeitures. The Administrator will determine the aggregate forfeitures under the Health Care Spending Accounts for any particular Plan Year, and will: (a) first, apply such forfeitures, insofar as possible, to the reasonable expenses of maintaining and administering the Plan and to offset any losses experienced by the Plan as a result of making reimbursements for the Plan Year in which the forfeiture occurs; and (b) second, to reduce required premiums or to reduce the cost of administering the Plan for the following Plan Year (or may be returned, in a reasonable and uniform basis as dividends or premium refunds, to Participants as of the end of the current Plan Year). Forfeitures may not be allocated based upon Participants' individual claims experience.

(c) Unclaimed Benefits. Any benefit payments remaining unclaimed (e.g., uncashed checks) for more than one year after issuance of the corresponding reimbursement check will be forfeited and the forfeited amounts will be returned to the Company to the extent permitted by law.

Section 7.08 Qualified Reservist Distributions. A QRD may be made if the Participant provides the Administrator with a copy of the order or call to active duty and the Administrator determines that the order or call is for a period of active duty of 180 days or more or is indefinite. If the period specified is less than 180 days, a QRD will not be permitted unless subsequent calls or orders increase the total period of active duty to 180 days or more. A QRD may be made in the amount contributed to the Health Care Spending Account as of the date of the QRD request, minus reimbursements paid as of the date of the QRD request. Additional claims may not be submitted for Medical Care Expenses incurred after the date a QRD is requested. The Administrator will pay the QRD to the Participant within a reasonable time, but not more than 60 days after the request for the QRD has been made. A QRD may not be made with respect to a Plan Year ending before the order or call to active duty.

ARTICLE VIII
DEPENDENT CARE SPENDING ACCOUNT

Section 8.01 Type of Benefit. Pursuant to Article V, a Participant may elect to contribute a portion of his or her Compensation to a Dependent Care Spending Account on a pre-tax basis. The amount contributed to the Dependent Care Spending Account is used to reimburse the Participant for Dependent Care Expenses as defined in Section 8.04. The Dependent Care Expense benefit is intended to be a dependent care assistance plan benefit within the meaning of Section 129 of the Code, and a flexible spending arrangement within the meaning of Regulation Section 1.125-5 or subsequent guidance. The Company and the Administrator will take whatever steps necessary to maintain and operate the Dependent Care Spending Account in accordance with the nondiscrimination requirements of Sections 129 and 125 of the Code.

Section 8.02 Maximum Contribution. The minimum and maximum amounts a Participant can elect to have contributed to his or her Dependent Care Spending Account will be determined by the Company each year and communicated to Participants in the annual enrollment materials; provided, however, that in no event will such amount exceed $5,000, or $2,500 for a married taxpayer filing as a single individual.

Section 8.03 Benefits During a Leave of Absence or After Termination.

(a) If a Participant ceases to be a Participant in this Dependent Care Spending Account for any reason during a Plan Year, the Participant's election to contribute to the Dependent Care Spending Account will terminate. The Participant will be entitled to reimbursement only for Dependent Care Expenses incurred within the same Plan Year and its related Grace Period prior to termination of employment, if the expenses are reimbursable under Section 8.04, and only if the Participant applies for such reimbursement in accordance with Section 8.06. No such reimbursement will exceed the remaining balance, if any, in the Participant's Dependent Care Spending Account for the Plan Year in which the expenses were incurred. In the event of the Participant's death, the Participant's spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under this Section.

(b) In the event a Participant does not have coverage under the Dependent Care Spending Account during FMLA leave (because the Participant chooses to revoke coverage or does not pay the required Participant Contributions for any reason during such leave), upon returning from such leave within the same Plan Year as such leave began, the Employer will reinstate the Participant's Dependent Care Spending Account coverage. Upon reinstatement of coverage, the Participant may choose to:

(i) reinstate his per pay period deduction under the Dependent Care Spending Account, in which case the Participant's elected annual Participant Contributions will be prorated for the period during which no contributions were paid, and reduced by prior reimbursements; or

(ii) resume Participant Contributions at the same annual contribution level, in which case the Participant's per pay period deduction under the Dependent

Care Spending Account will be adjusted to an amount equal to the annual Participant Contributions less the actual Participant Contributions, divided by the number of pay periods remaining in the Plan Year. Notwithstanding the provisions of this subparagraph (ii), if the Plan has already made disbursements to the Participant that exceed the Participant Contributions that will be paid for the Plan Year, the Employer may not require the Employee to pay any more than the remaining Participant Contributions due.

In no event will reimbursements be permitted for any otherwise eligible expenses incurred during such leave.

(c) If the Dependent Care Spending Account coverage continues during the FMLA leave, the Participant's contributions will continue as though he or she is not on a Leave of Absence.

Section 8.04 Dependent Care Expenses. Each Participant will be entitled to reimbursement from his or her Dependent Care Spending Account for those Dependent Care Expenses incurred during a Plan Year and its Related Grace Period that are eligible employment-related expenses under the child and dependent care credit provisions of Section 21(b)(2) of the Code and that do not exceed the earned income limit specified in Section 8.05, but only to the extent of the balance in the Participant's Dependent Care Spending Account when the claim is processed for such Plan Year or its related Grace Period.

The following rules (and any other applicable rules of Sections 21(b)(2) and 129 of the Code) apply in determining whether a Participant's expenses are for reimbursable "Dependent Care Expenses" under this Article:

(a) The expenses must be incurred to enable the Participant (and if the Participant is married, the Participant's Spouse) to be gainfully employed (or in active search of employment) during the period in which there is at least one qualifying individual (as defined in Section 8.04(b)) in the Participant's household, and the expenses must be for either (i) expenses for household services that are attributable in part to the care of a qualifying individual, or (ii) expenses for the care of a qualifying individual. Educational expenses for a child in kindergarten or higher grade level are not payments for the care of a qualifying individual eligible for reimbursement.

(b) "Qualifying individuals" are any of the following persons:

(i) A Section 152 Dependent who has not attained age 13;

(ii) A Section 152 Dependent who is physically or mentally incapable of caring for himself or herself and who regularly spends at least 8 hours per day in the Participant's household; or

(iii) A Spouse who is mentally or physically incapable of caring for himself or herself and who regularly spends at least 8 hours per day in the Participant's household

With respect to (i) and (ii) above, a child will be a qualifying individual only with respect to a Participant who is the child's custodial parent (the parent with whom the child resided for the greater number of nights during the calendar year.

(c) This Plan will not reimburse a Participant for payments made to either (i) a child of the Participant if the child was under age 19 at the end of the Plan Year, or (ii) a person the Participant or the Participant's Spouse can claim as a dependent for federal income tax purposes.

Section 8.05 Earned Income Limit. For any Plan Year and its related Grace Period, reimbursement under this Plan for Dependent Care Expenses will not exceed the Participant's earned income limit calculated under the following rules. For purposes of this Section 8.05, "earned income" means the total wages, salary, and other Employee compensation and any net earnings from self-employment for the Plan Year.

(a) In the case of a Participant who is not married at the close of the Plan Year, the limit equals the Participant's earned income.

(b) In the case of a Participant who is married at the close of the Plan Year, the limit equals the lesser of the Participant's earned income or the earned income of the Participant's Spouse.

(c) During any month in the Plan Year, if the Participant's Spouse is either a full-time student at an educational institution or is physically or mentally not able to take care of himself, the Spouse will be deemed to have "earned income" for that month of $250.00 (or $450.00 if there are at least two qualifying individuals (as defined in Section 8.04).

(d) A married Participant who is legally separated or living apart will be considered not married if he or she is treated as not married under the rules of Sections 21(e)(3) and (4) of the Code.

Section 8.06 Claim and Payment Procedures. A Participant must file claims for reimbursement of eligible Dependent Care Expenses from his or her Dependent Care Spending Account with the Claims Administrator on the appropriate form furnished by the Claims Administrator. The Participant will be required to furnish receipts and statements from the providers of dependent care, but the Participant will complete the provider information section of the claim form and certify that this information is true.

All claims submitted by a Participant during a reimbursement period will be processed as of the end of that reimbursement period on the basis of the balance in the Participant's Dependent Care Spending Account for at the end of such reimbursement period. To the extent that any claims cannot be paid in full because credit in the Participant's Dependent Care Spending Account is insufficient to cover the claim, the claim will be held for payment in the next succeeding reimbursement period(s) of such Plan Year, but will not be carried over or charged against the balance of any subsequent Plan Year.

Payments pursuant to this Section will be made only to Participants, and no payment will be made directly to the provider of the dependent care.

Expenses incurred during a Plan Year's related Grace Period will be reimbursed from a Participant's Dependent Care Spending Account for such Plan Year, pursuant to this Section 8.06, so long as funds remain in the Participant's Dependent Care Spending Account for such Plan Year. After a Participant's Dependent Care Spending Account for such Plan Year has been exhausted, expenses incurred during the Grace Period may be reimbursed from the Participant's Dependent Care Spending Account for the Plan Year containing the Grace Period, if applicable, subject to the requirements set forth in this Section 8.06.

Section 8.07 Forfeitures; Use It or Lose It Rule.

(a) Use It or Lose It Rule. Claims received by the Administrator after the December 31 deadline immediately following the close of a Plan Year for expenses incurred during that closed Plan Year will be untimely and not eligible for reimbursement under the Plan. A Participant or former Participant will not be entitled to receive cash or any other form of compensation or benefits with respect to any unused balance in his Dependent Care Spending Account after all timely claims have been processed as of the end of a Plan Year. Similarly, no balance remaining after the expiration of the period for submitting claims for one Plan Year will be carried forward into any succeeding Plan Year.

(b) Use of Forfeitures. The Administrator will determine the aggregate forfeitures under the Dependent Care Spending Accounts for any particular Plan Year, and will: (a) first, apply such forfeitures, insofar as possible to the reasonable expenses of maintaining and administering the Plan and to offset any losses experienced by the Plan as a result of making reimbursements for the Plan Year in which the forfeiture occurs; and (b) second, to reduce required premiums or to reduce the cost of administering the Plan for the following Plan Year (or may be returned, in a reasonable and uniform basis as dividends or premium refunds, to Participants as of the end of the current Plan Year).

(c) Unclaimed Benefits. Any benefit payments remaining unclaimed (*e.g.*, uncashed checks) for more than one year after issuance of the corresponding reimbursement check will be forfeited and the forfeited amounts will be returned to the Company to the extent permitted by law.

Section 8.08 Statements. The Administrator will issue to each Participant in writing at the conclusion of each Plan Year a statement describing the total credits to his or her Spending Account for such Plan Year and the type and amount of debits from his or her Spending Account for such Plan Year and its related Grace Period.

ARTICLE IX
HEALTH REIMBURSEMENT ACCOUNT

Section 9.01 Type of Benefit. Pursuant to this Article, the Plan may offer a Health Reimbursement Account integrated with one or more of its self-funded group health program offerings, subject to the terms of the applicable Benefit Program. Amounts are allocated to the Health Reimbursement Account of a Participant as provided under the applicable Benefit Program, and are then used to reimburse the Participant for Medical Care Expenses. The Employer is solely responsible for periodically funding the Health Reimbursement Account. Unused amounts in each Health Reimbursement Account will accrue from year to year at the Employer's sole discretion and may be revised prior to the commencement of each new Plan Year. No interest may be earned on unused balances.

Section 9.02 Maximum Contribution. The minimum (if any) and maximum amounts that may be allocated to a Health Reimbursement Account will be determined by the Company each year and communicated to Participants in the annual enrollment materials.

Section 9.03 Benefits After Termination. A Participant in the Health Reimbursement Account who terminates employment and who does not elect continuation coverage as provided for herein, will forfeit any amounts under the Health Reimbursement Account (except as may be provided for under any applicable retiree program for which the Participant is then eligible). Such former Employee will continue to be eligible to claim reimbursement for expenses incurred before the effective date of the former Employee's termination of employment.

Section 9.04 Claim and Payment Procedures. A Participant must file claims for reimbursement of Medical Care Expenses from his Health Reimbursement Account to the Claims Administrator in the manner prescribed by the Claims Administrator. Properly submitted claims will be paid monthly or when the total amount of the claims submitted is at least the minimum amount specified by the Administrator. Claims will be honored only if:

(a) incurred for Medical Care Expenses of the Participant or his eligible dependent;

(b) the Medical Care Expenses were incurred on or after the date the Participant had established a Health Reimbursement Account and while the Participant remains a qualifying employee or the dependent remains a Section 152 Dependent; and

(c) substantiated by (A) a written statement from an independent third party (such as the service provider) stating that the expense was incurred, identifying the treatment or service provided, the date of service, and the amount of the expense; and (B) a written statement from the Participant that the expense has not been reimbursed and is not reimbursable from any other source of coverage. If an explanation of benefits is submitted indicating the date of the service and the amount the Participant is responsible to pay, together with the statement described in (B) above, the claim will be deemed fully substantiated.

For this purpose, a Participant or eligible Dependent has incurred a Medical Care Expense when he or she receives the medical care that gives rise to the Medical Care Expense, regardless of when the Participant or his or her eligible Dependent is formally billed or charged for, or pays the Medical Care Expense.

Payments pursuant to this Section will be made only to Participants, and no payment will be made directly to the provider of the medical care services, treatment or supplies.

ARTICLE X
ADOPTION ASSISTANCE

Section 10.01 Type of Benefit. Pursuant to this Article, the Plan provides for the reimbursement of Adoption Expenses incurred in connection with the adoption of an Eligible Child by an eligible Participant pursuant to Section 137 of the Code, and as further described in the Program Documents.

Section 10.02 Limit on Adoption Expenses. A Participant is only eligible for reimbursement of Adoption Expenses that are incurred after the date he or she becomes a Participant and while he or she remains an Employee. Adoption Expenses incurred before or after that time period are not eligible for reimbursement hereunder. The maximum amount that may be covered will be determined by the Company each year and communicated to Participants in the annual enrollment materials; provided, however, that in no event will such amount exceed the dollar amount set forth in Section 137 of the Code, as adjusted for inflation. Adoption Expenses are only reimbursed after the expenses are incurred and the adoption of the Eligible Child becomes final. Only successful adoptions are eligible for reimbursement.

Section 10.03 Claim and Payment Procedures. A Participant must file claims for reimbursement of Adoption Expenses to the Claims Administrator in the manner prescribed by the Claims Administrator. Claims will be honored only if:

(a) the Adoption Expenses fall within the limitations specified under Section 10.02 above;

(b) the claim is submitted no later than 90 days after the adoption becomes final;

(c) the claim will include (i) a copy of the final adoption decree, (ii) an itemized list of the costs incurred and proof of payment of those costs, (iii) the name, age and tax identification number (TIN), if known, of the adopted child;

(d) the Participant has been reimbursed from all other sources legally obligated to provide reimbursement.

Within 90 days of the receipt of the claim mentioned above, the Claims Administrator will furnish the Participant with notification of whether the Participant is entitled to a benefit under this Article and, if so, will deliver to the Participant payment, less any applicable withholding taxes.

ARTICLE XI
SPECIAL COVERAGE PROVISIONS

Section 11.01 COBRA Continuation Coverage. This section will only apply to Benefit Programs that would be considered a "group health plan" under Section 5000(b)(1) of the Code. Although not required by Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, the Plan will extend continuation coverage that is similar to COBRA to Domestic Partners in accordance with the terms of this Section 11.01. The rights provided to Domestic Partners shall be identical to those provided to spouses under this Section 11.01, except where otherwise noted. Notwithstanding the foregoing, nothing in this Section 11.01 shall create a COBRA right or remedy for any such Domestic Partner. The Plan will offer continuation coverage to eligible Participants to the extent required by applicable state insurance law governing health insurance continuation.

(a) Qualifying Events. A Participant or qualified beneficiary who would otherwise lose group health plan coverage as a result of a "qualifying event," as defined below, will be entitled to elect continuation of group health plan coverage under the Benefit Program as provided by COBRA. The coverage will be identical to the coverage provided persons to whom a qualifying event has not occurred. If coverage is modified for individuals who have not incurred a qualifying event, continuation coverage will be modified in the same way for individuals who have elected COBRA continuation coverage. A "qualifying event" is any of the following:

(i) termination as an Employee (other than for gross misconduct) or reduction of hours worked so as to render the Participant ineligible for group health plan coverage under a Benefit Program, including termination of employment following a leave under FMLA;

(ii) the Participant's death;

(iii) divorce or legal separation of the Employee from his or her Spouse;

(iv) for a Spouse and Section 152 Dependent children, loss of coverage due to the Participant becoming entitled to Medicare; or

(v) for a Section 152 Dependent child, ceasing to qualify as an eligible Dependent under the applicable Benefit Program.

To lose coverage means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event; provided that if coverage is reduced or eliminated in anticipation of an event (e.g., in anticipation of a divorce), then the reduction or elimination is disregarded in determining whether an event would cause a loss of coverage.

(b) Qualified Beneficiary. For purposes of this Section 11.01, a "qualified beneficiary" includes a Participant's Section 152 Dependent child and/or Spouse who is a covered Dependent under a Benefit Program that is a group health plan subject to the requirements of COBRA on the day before a qualifying event, as provided in Section 4980B(g) of the Code. "Qualified beneficiary" will also mean a child who is born to or placed for adoption with the Participant

during the period of COBRA continuation coverage, provided that the Participant notifies the Administrator in writing within 30 days of the child's birth, adoption or placement for adoption.

(c) Notice to Administrator. The Administrator may establish reasonable procedures for providing the notices required by this Section 11.01(c).

(i) A Participant or his or her qualified beneficiary must notify the Administrator in writing within 60 days after the later of:

(A) the date of a divorce or legal separation or the date an eligible Section 152 Dependent child will cease to qualify as an eligible Dependent under the applicable Benefit Program, or the date of a second qualifying event; or

(B) the date coverage would be lost as a result of the event; or

(C) the date on which the qualified beneficiary is informed of the responsibility to provide notice and the Plan's procedures for providing notice to the Administrator.

All rights to continued Benefit Program coverage will be lost by the failure to timely give this required written notice to the Administrator.

(ii) An eligible Participant may elect COBRA continuation coverage for an eligible child who is born to, adopted by, or placed for adoption with such Participant while the Participant's COBRA continuation coverage (or right to elect COBRA continuation coverage) is effective, provided that the Participant has notified the Administrator in writing within 30 days of the child's birth, adoption, or placement for adoption.

(iii) An Employer will notify the Administrator of the following qualifying events within 30 days of the event or within 30 days following the date coverage ends if the Benefit Program provides that continuation coverage commences on the date coverage is lost:

(A) the Participant's death;

(B) termination or reduction in hours that the Participant works; or

(C) the Participant becoming entitled to Medicare.

(iv) A Participant or qualified beneficiary entitled to COBRA continuation coverage with a maximum duration of 18 months will notify the Administrator if found by the Social Security Administration to have been disabled at any time during the first 60 days of continuation coverage. This notice must be given within 60 days after the later of:

(A) the date of the disability determination by the Social Security Administration;

(B) the date on which the qualifying event occurred;

(C) the date on which the Participant or qualified beneficiary loses or would lose coverage under the Plan as a result of the qualifying event; or

(D) the date on which the Participant or qualified beneficiary is informed of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Administrator;

provided, however, that the notice is received before the end of the first 18 months of COBRA continuation coverage.

(v) A Participant or qualified beneficiary who has been found to have been disabled (as described in Section 11.01(c)(iv)) will notify the Administrator of a subsequent determination by the Social Security Administration that the individual is no longer disabled. This notice must be provided within 30 days after the later of:

(A) the date of the final determination by the Social Security Administration that the disabled individual is no longer disabled; or

(B) the date on which the disabled Participant or qualified beneficiary is informed of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Administrator.

(d) Notice to Participant and Qualified Beneficiary.

(i) The Administrator must advise the Participant and all qualified beneficiaries of the right to continue coverage not later than:

(A) 14 days after being notified of a qualifying event, or

(B) if the Employer is the Administrator, not later than 44 days after occurrence of the qualifying event or, if the Benefit Program provides that continuation coverage commences the date coverage is lost, not later than 44 days after the date coverage is lost.

(ii) If the Administrator receives a notice under Section 11.01(c) and the individual is not entitled to COBRA continuation coverage, the Administrator will provide notice to the individual that COBRA coverage is unavailable.

(iii) If COBRA coverage terminates earlier than the end of the maximum period described in Section 11.01(g), then the Administrator will provide notice to

the Participant and his or her qualified beneficiary of the date of termination (in accordance with applicable regulations) as soon as possible following the Administrator's determination that coverage will terminate.

(iv) Notice of the right to continued coverage to a qualified beneficiary Spouse will be deemed notice to any qualified beneficiary children residing with such Spouse. Notwithstanding the preceding sentence, a single notice addressed to a Participant and Spouse may be provided under this Article, provided that the most recent information available to the Administrator indicates that both reside at the same address. Each qualified beneficiary that is a covered Section 152 Dependent child may be notified by providing a single notice to either the Participant or Spouse, provided that the most recent information available to the Administrator indicates that the Section 152 Dependent resides at the same address as the individual to whom notice was given. An election to receive or to waive coverage for a Section 152 Dependent child may be made by the Participant or his or her Spouse with whom the Section 152 Dependent child resides.

(e) Election of Coverage. If the Participant or qualified beneficiary do not elect continuation coverage within this election period, then the right to continuation coverage based on COBRA rules will be lost. Coverage must be elected within 60 days of the latest of the following:

(i) the qualifying event; or

(ii) the date the Participant or qualified beneficiary is advised by the Administrator of the right to continued coverage.

(f) Payment for Coverage.

(i) The Participant and/or qualified beneficiary will be required to pay up to 102% of the group rate for the continued coverage as determined by the Administrator and have the option to make these payments in monthly installments. Such monthly installment payments are due by the 30th day after the first day of the month for which payment is made. Installments that are paid later than such 30-day grace period will not be deemed timely and will result in coverage being terminated.

(ii) Contribution amounts and benefits for continuation coverage are subject to change. The Participant will be notified of any changes in contribution amounts or benefits available under the applicable Benefit Program.

(iii) If the Participant or qualified beneficiary elects continuation of coverage after the qualifying event, then the Participant or qualified beneficiary will have 45 days from the date of election to start paying for that coverage. The first payment must include the cost of coverage for the entire period from the date coverage was lost due to the qualifying event at least through the date of payment. There is no grace period for the first payment. Subsequent monthly installment payments are due by the 30th day after the first day of

the month for which payment was late. Installments that are paid after such 30 day grace period will not be deemed timely and will result in COBRA coverage being terminated.

(iv) The Benefit Program will not be required to bill covered individuals for continuation coverage. If any payment for continuation coverage is postmarked or otherwise sent after the date that payment is due, continuation coverage under the Benefit Program will terminate and will not be reinstated. An exception will be made for "insignificant underpayment" of a monthly installment. A payment will be deemed an insignificant underpayment provided that the deficiency is no greater than the lesser of:

(A) $50 or such other amount as the Internal Revenue Service Commissioner may provide; or

(B) 10% of the installment amount due.

In such a case, the Plan will notify the Participant of the deficiency, and the Participant will have 30 days from the date of such notice to pay the deficiency.

(v) Notwithstanding the foregoing, if a Participant terminates employment with the Employer under an individual voluntary or involuntary severance or separation program, plan, or agreement, in the Employer's sole discretion, payment of all or a portion of the contributions required to be paid by the Participant may be made on a pre-tax basis from such severance payments. For purposes of this Section 11.01(f)(v) only, and if elected by the Employer, Compensation will also include payments made to a Participant under a voluntary or involuntary severance or separation program, plan, or agreement.

(g) Period of Coverage.

(i) If elected, the maximum period for continued coverage is as follows:

(A) 18 months from the date coverage is lost on account of a qualifying event involving termination of employment or reduction in hours; and

(B) 36 months from the date coverage is lost on account of any other qualifying event.

(ii) The maximum period described in subparagraph (i)(A) may be extended if:

(A) COBRA continuation coverage is triggered by the Participant's termination of employment or reduction in hours and either the Participant or qualified beneficiary is found by the Social Security

Administration to have been disabled at any time during the first 60 days of continuation coverage, then the disabled person and his or her covered family members will be eligible for up to 29 months of continued coverage (an additional 11 months). The Administrator may assess an increased charge of up to 150% of the cost of Benefit Program coverage for the additional 11 months of coverage; or

(B) If a second qualifying event that gives rise to a 36-month maximum coverage period occurs within the applicable 18 or 29 month period, the period of coverage may be extended up to 36 months from the date of the first qualifying event for the Participant's qualified beneficiary Spouse and qualified beneficiary child. This extended coverage period will be available when one of the following events occurs during such original period of continued coverage:

(1) the Participant's death;

(2) divorce or legal separation of the Participant from his qualified beneficiary Spouse; or

(3) for a qualified beneficiary child, ceasing to qualify as an eligible Dependent under the applicable Benefit Program.

To be eligible for this additional coverage, the Participant or his qualified beneficiary must notify the Administrator in writing within 60 days of the second qualifying event and before the applicable 18 or 29 month period of continued coverage ends.

(iii) Coverage will end before the end of the maximum period on the first of the following, if any, to occur:

(A) the date all Employers cease to provide any group health plan coverage to any Employee;

(B) the date the Participant or qualified beneficiary fails to make any required installment contribution payment;

(C) the date that there has been a final determination by the Social Security Administration that the Participant or qualified beneficiary who has elected to extend coverage for up to 29 months due to disability is no longer disabled;

(D) the Employer terminates the Employee's coverage for cause (for example, submission of a fraudulent claim by the Employee); or

(E) the first day after the Participant or qualified beneficiary makes a COBRA election on which the Participant or qualified beneficiary, becomes:

(1) a covered employee or dependent under any other group health plan other than TRICARE or any other government-sponsored medical care program while that person is on a Leave of Absence under USERRA; or

(2) entitled to Medicare.

However, if the Participant or qualified beneficiary becomes covered by another group health plan and has a pre-existing condition that is not covered by that other plan, then COBRA coverage (at least for that pre-existing condition) will not be terminated due to such other coverage.

(iv) Continuation coverage is provided subject to eligibility under the law. The Administrator reserves the right to terminate continuation coverage retroactively if the individual is determined to be ineligible for continuation coverage. The Administrator intends to provide continuation coverage only to the extent required by law and will administer continuation coverage according to those requirements. This Section will not create any rights in excess of the minimum required by law.

(h) Health Reimbursement Account. If a Participant or qualified beneficiary experiences a qualifying event and elects COBRA continuation coverage, the maximum reimbursement will be the value of the Health Reimbursement Account on the date of the qualifying event. COBRA continuation coverage will extend for a Participant or a qualified beneficiary until the earlier of (1) the maximum period, or (2) the date a Participant or qualified beneficiary spends down the Health Reimbursement Account balance in effect as of the date of the qualifying event. If a Participant or qualified beneficiary independently experiences a qualifying event, that individual will also have access to the full Health Reimbursement Account balance. This will not impact the Health Reimbursement Account balance of the Participant and/or any qualified beneficiaries who have not experienced a qualifying event.

(i) Continuation Coverage After Relocation. If a Participant or qualified beneficiary relocates to an area not served by his or her region-specific health coverage benefit program or option, the Participant or qualified beneficiary will be given, within a reasonable period of time after requesting other coverage, an opportunity to elect alternative or extended coverage if there is another program or option available to Participants who have not experienced a qualifying event that will serve the Participant's or qualified beneficiary's health care needs. The alternative coverage must be effective as of the later of the date of the Participant's or qualified beneficiary's relocation, or the first of the month following the month in which the alternative coverage is requested.

(j) Annual Enrollment. In the event that an annual enrollment occurs during a period of COBRA continuation coverage, the affected Participant or qualified beneficiary will be given the same right that is provided to active Employees to choose other coverage or another benefit option under a group health plan under which he or she would otherwise be entitled to coverage under this Section.

(k) Trade Adjustment Assistance Rights. A Participant or Dependent who lost group health plan coverage as a result of the Participant's termination of employment and did not elect COBRA continuation coverage in connection with such loss will have a second opportunity to elect such coverage during the 60-day period that begins on the first day of the month in which the Participant becomes eligible for trade adjustment assistance ("TAA") under the provisions of the Trade Act of 2002, but only if such election is made not later than six months after the date of the Participant lost coverage due to the termination of employment that entitles him to TAA. To be eligible for this second election, the Participant or his or her Dependent Spouse must notify the Administrator in writing of such TAA eligibility within 60 days of the date the Participant becomes eligible for TAA. Coverage elected in accordance with this Section 11.01(k) will become effective at the beginning of the 60-day election period described above.

Section 11.02 Conversion of Coverage. Unless the Program Documents provide otherwise, the Plan will not provide conversion coverage; provided, however, that nothing in a Benefit Program will preclude a Participant from exercising any conversion option made available to him or her by an Insurance Company under an Insurance Company contract. Unless the Program Documents provide otherwise, neither the Administrator nor any Employer will have any obligation to provide notice of any such conversion option.

Section 11.03 Pre-existing Condition Limitation. There will be no pre-existing condition limitation under any HIPAA Program. Pre-existing condition limitations may apply to Benefit Programs, other than a HIPAA Program, to the extent provided by the Benefit Program.

Section 11.04 Required Coverage. Notwithstanding anything contained in any Program Document to the contrary, the following provisions will apply to each Benefit Program:

(a) Minimum Hospital Stay. To the extent required by the Newborns' and Mothers' Health Protection Act of 1996, as amended from time to time, each Benefit Program may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Benefit Program may not, under federal law, require that any provider obtain authorization from the Benefit Program for prescribing a length of stay not in excess or 48 hours (or 96 hours). A Benefit Program may require, as a condition of the Participant reducing his or her out-of-pocket costs, a Participant to notify it in advance of a hospital admission in connection with a childbirth. This Section will not create any rights in excess of the minimum required by law.

(b) Mental Health and Substance Abuse Disorder Benefits. The Plan will comply with MHPAEA, to the extent MHPAEA is applicable to the Plan. Nothing in the Plan will be construed

to require any Benefit Program to provide mental health and/or substance use disorder benefits. This subsection (b) will not create any rights in excess of the minimum required by law.

(c) Benefits for Reconstructive Surgery Following Mastectomy. To the extent required by the Women's Health and Cancer Rights Act of 1998, as amended from time to time, each Benefit Program subject to that act will provide coverage to a Participant or Dependent who elects breast reconstruction in connection with a mastectomy for (i) all stages of reconstruction of the breast in which the mastectomy was performed; (ii) surgery and reconstruction of the other breast to produce symmetrical appearance; and (iii) prostheses and physical complications of mastectomy, including lymph edemas. Such coverage will be provided in a manner determined in consultation with the treating physician and Participant or Dependent. This Section will not create any rights in excess of the minimum required by law.

ARTICLE XII
COORDINATION OF BENEFITS AND RECOVERY OF BENEFIT OVERPAYMENT

Section 12.01 Coordination of Benefits. Except as specifically provided otherwise in an applicable Program Document, this Section will apply to the coordination of benefits with respect to any medical or health benefit.

(a) General. The rules set forth in this Section coordinate the payment of benefits under the Plan with other group medical plans under which a Participant or covered Dependent is covered so that the Participant or covered Dependent receives all of the benefits to which he is entitled, but not to exceed 100% of total allowable expenses. When a claim is made, the order of benefit determination rules set forth below determine whether the Plan is a "primary plan" or a "secondary plan." When the Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When the Plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits. No plan pays more than it would without the coordination provision.

(b) Definitions. For purposes of this Section, the following definitions will apply:

(i) An "allowable expense" means any necessary, reasonable health care service or expense, including deductibles and copayments, that is covered, at least in part, by any of the other group medical plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service, or a portion thereof, that is not covered by any of the plans is not an allowable expense.

(ii) "Other group medical plans" means the following types of medical, dental and vision care benefits:

(A) coverage under a governmental program or provided or required by law, except a state Medicaid plan under Title XIX of the Social Security Act;

(B) group insurance or group-type coverage, whether insured or uninsured. This includes group or group type coverage under health maintenance organizations and other pre-payment group practice or individual practice coverage;

(C) group-type contracts that are contracts not available to the general public and that can be obtained and maintained only because of membership in or in connection with a particular organization or group; and

(D) medical benefits coverage under group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts.

Each contract or other arrangement is a separate group medical plan. If an arrangement has two parts and the coordination of benefit rules apply only to one of the two, each of the parts is a separate group medical plan.

(c) Order of Benefit Determination Rules. When two or more plans pay benefits, a plan without a coordinating provision is always the primary plan. If all plans have such a provision, the first of the following rules that describes which plan is primary will determine the order of payment:

(i) Non-Dependent or Dependent. The plan under which the individual is the eligible individual (rather than a covered Dependent) is primary and the other is secondary, unless such person is a Medicare beneficiary.

(ii) Child of Parents Not Separated or Divorced. If a covered Dependent child is covered under both parents' plans, the birthdays of the covered Dependent child's parents are used to determine which plan is primary. The plan of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be primary. If both parents have the same birthday, then the plan that has had coverage in effect for the covered Dependent child for the longest period of time is primary.

(iii) Child of Parents Separated or Divorced. If the parents are separated or divorced and a court order makes one parent responsible for the child's health care, the plan of that parent is primary. If there is no court order, the following will apply:

(A) the plan of the parent with custody is primary;

(B) the plan of the person married to the parent with custody (step-parent) is secondary; and

(C) the plan of the parent without custody pays third.

If neither paragraphs (i), (ii) or (iii) applies, the plan covering the individual for the longest period of time is primary.

(iv) Stepchild of a Participant or Child of a Domestic Partner. If a Participant's stepchild or the child of a Participant's Domestic Partner is also covered under a plan of the child's parent, the plan of the parent will be primary.

(v) Active or Inactive Employee. The plan that covers a person as an employee who is neither laid off nor retired (or as that person's dependent) is primary. 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.

(vi) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is 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.

(vii) Longer or Shorter Length of Coverage. The plan that covered the person longer is primary.

(viii) Other Rules Do Not Apply. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans. In addition, the Plan will not pay more than it would have paid had it been primary.

(d) Right to Receive and Release Needed Information. Certain facts about health care coverage and services are needed to apply these coordination of benefits rules and to determine benefits payable under this Plan and other plans. A Participant or covered Dependent will give information about coverage under any other plans under which such individual is covered when he submits a claim for benefits under a Benefit Program. The Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Administrator need not tell, or get the consent of, any person to do this.

(e) Facility of Payment. A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

(f) Right of Recovery. If the amount of the payments made by the Administrator is more than it should have paid under this coordination of benefits provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Section 12.02 Medicare-Eligible Employees and Dependents. This Section will only apply to "medical benefits" (within the meaning of Medicare) provided under the Benefit Programs.

(a) Each Medicare-eligible Employee covered by a Benefit Program providing medical benefits will continue to be covered by such Benefit Program, unless he or she refuses (in writing) the medical benefits provided under such Benefit Program in favor of Medicare primary coverage.

(b) Each Medicare-eligible Dependent of an Employee covered by a Benefit Program providing medical benefits will continue to be covered by such Benefit Program, unless he or she refuses (in writing) the medical benefits provided under such Benefit Program in favor of Medicare primary coverage.

(c) Notwithstanding anything in subsections (a) or (b) to the contrary, Medicare will automatically be the primary coverage for a Medicare-eligible Participant who is covered by an applicable Benefit Program and who:

(i) begins a regular course of renal dialysis;

(ii) receives a kidney transplant without first beginning dialysis; or

(iii) becomes disabled for Medicare purposes

at the earliest time at which Medicare is permitted to be primary under Section 1862(b) of the Social Security Act and regulations thereunder, regardless of whether such person actually enrolls for Medicare.

(d) To the extent permitted by law, Medicare will be the primary coverage for a Participant (other than an Employee) or Dependent who is covered by an applicable Benefit Program and who attains age 65.

Section 12.03 Subrogation, Reimbursement and Recovery for Third Party Liability. As a condition for receiving benefits under the Plan, each Covered Person agrees to and grants the Plan the right to subrogation, the right to reimbursement, and the right of recovery as set forth herein. When a Covered Person becomes sick or injured as a result of the act or omission of another person or party and the Covered Person received benefits under the Plan for such injuries, the Covered Person must reimburse the Plan for benefits received from all recoveries from a Third party (whether by lawsuit, settlement or otherwise) and the Plan's share of the recovery will not be reduced because the Covered Person has not received the full damages claims, unless the Plan agrees in writing to such a reduction. If the Covered Person breaches this Third Party reimbursement provision, then the Covered Person agrees to indemnify the Plan for all costs of recovering Third Party reimbursements. To the extent that any Program Document also contains provisions regarding subrogation, reimbursement, or right to recovery of expenses, this Section 12.03 and the applicable Program Document will both apply so as to grant the Plan the greatest possible rights with respect to subrogation, reimbursement, and recovery of such expenses or benefits. Except as specifically provided otherwise in an applicable Program Document, this Section 12.03 will apply to any health or disability benefit provided through the Benefit Programs.

(a) Right of Subrogation. As a condition to participation in or the receipt of benefits under the Plan, each Covered Person agrees that the Plan will have the right of subrogation with respect to the full amount of benefits paid to or on behalf of a Covered Person as the result of an injury, illness, disability or death that is or may be the responsibility of any Third Party. The Plan will also have a lien upon any recovery from such Third Party to the full amount of benefits paid and may, at its option, file suit or intervene in any pending lawsuit to secure and protect its rights. The Plan's right of subrogation will apply to the first dollar of any recovery obtained from the Third Party, even if the recovery obtained is less than the amount needed to make the Covered Person whole.

(b) Reimbursement Agreement. If a Covered Person incurs expenses that are excluded in accordance with this provision of the Plan because they are or may be the responsibility of a Third Party, the Covered Person will be required, as a prerequisite to receiving Plan benefits, to

sign a reimbursement agreement in a form acceptable to the Administrator acknowledging the Covered Person's obligation to reimburse the Plan for any benefits or expenses paid by the Plan from the first dollars recovered from any source. If expenses are incurred by a minor, the Administrator may require that the minor's parent or legal guardian execute the reimbursement agreement and agree to be bound by it. The Administrator may, in its discretion, withhold benefit payments that might otherwise be advanced, and/or initiate an action at law or in equity in its own name or in the name of the Covered Person, in order to enforce, secure, or protect the Plan's rights under this provision. If the Covered Person elects not to execute such an agreement, the Plan is not obligated to provide any benefit payments.

(c) Right of Reimbursement. Whether or not a Covered Person executes a reimbursement agreement, in the event that the Plan provides benefits to a Covered Person and the Covered Person recovers a payment, either by settlement, judgment, no-fault automobile insurance statute, or otherwise, from any Third Party or other source, then the Covered Person will immediately reimburse the Plan for the full amount of any and all benefits paid in connection with such injury, illness, disability or death, up to the amount of the recovery. This right of reimbursement applies regardless of the label assigned to the recovery, and regardless of any purported allocation or itemization of such recovery to specific types of injuries. If the recovery is for damages other than for medical or dental care expenses, such as pain and suffering, the Covered Person will still be required to reimburse the Plan first. The Plan will have a lien upon any such recovery in the amount of benefits or expenses paid by the Plan. The Plan's right of reimbursement will apply to the first dollar of any recovery obtained from the Third Party, even if the recovery obtained is less than the amount needed to make the Covered Person whole.

(d) Procedures for Subrogation and Reimbursement. Each Covered Person or his or her legal representative must do whatever is requested by the Administrator with respect to the exercise of the subrogation and reimbursement rights of the Benefit Program and the Employers, and will do nothing to prejudice those rights. In addition, each Covered Person or his or her legal representative, in conjunction with making a claim for Benefit Program benefits, must inform the Administrator in writing whether the Covered Person was injured by a Third Party, and must provide the following information in a timely, prompt fashion as a condition to receipt of Benefit Program benefits:

(i) the name, address, and telephone number of the Third Party that in any way caused the injury, and of the attorney representing the Third Party;

(ii) the name, address, and telephone number of the Third Party's insurer and any insurer of the Covered Person;

(iii) the name, address, and telephone number of the Covered Person's attorney with respect to the Third Party's act;

(iv) prior to the meeting, the date, time and location of any meeting between the Third Party or his or her attorney and the Covered Person, or his or her attorney;

(v) all terms of any settlement offer made by the Third Party or his or her insurer or the Covered Person's insurer;

(vi) all information discovered by the Covered Person, or his or her attorney, concerning the insurance coverage of the Third Party;

(vii) the amount and location of any funds that are recovered by the Covered Person from the Third Party or his or her insurer or the Covered Person's insurer, and the date that the funds were received;

(viii) prior to settlement, all information related to any oral or written settlement agreement between the Covered Person and the Third Party or his or her insurer or the Covered Person's insurer;

(ix) all information regarding any legal action that has been brought on behalf of a Covered Person against the Third Party or his or her insurer; and

(x) all other information requested by the Administrator.

No Covered Person (or the person's legal representative) may retain an attorney with respect to the Third Party without the prior written consent of the Administrator. As a condition of receiving benefits under the Benefit Program, each Covered Person (and that person's legal representatives) hereby:

(i) waives the assertion of any attorney-client privilege against an Employer with regard to an attorney retained by the Covered Person;

(ii) agrees that an Employer may assume, at its discretion, the defense of any action that has been or could be brought against the Third Party by the Covered Person (or that person's legal representatives);

(iii) agrees that an Employer must be given the opportunity to approve any settlements before they are made with the Third Party;

(iv) agrees to consent to judgment for the Plan;

(v) agrees not to assert a defense under Section 502 of ERISA to a claim made by the Plan; and

(vi) agrees that a claim brought by the Plan to enforce its rights under this Section 12.03 is an equitable claim.

Any funds recovered by a Covered Person (or that person's legal representative) from a Third Party (or the Third Party's insurer) must and are deemed to be held in constructive trust for the benefit of the Benefit Program and the Participating Employer to the extent of the amount of Benefit Program benefits until reimbursement, with the Covered Person (or that person's legal representative) as trustee and fiduciary.

(e) Coverage for Expenses Caused by a Third Party. The Administrator may, in its sole discretion, cease to pay benefits under a Benefit Program if a Covered Person refuses to execute a reimbursement agreement. The Administrator may cease to pay benefits subject to a reimbursement agreement if, in the discretion of the Administrator, the Covered Person has failed or is failing to fulfill his or her duty to cooperate or to comply with the provisions of this Section 12.03.

(f) Right of Recovery and Offset. The Plan will have the right to recover any benefits paid to a Covered Person or his or her health care provider that a Covered Person fails to reimburse to the Plan under the provisions of this Section 12.03. To the extent not otherwise paid to the Plan, the amount due to the Plan will reduce any other present or future benefits payable from the Plan to or on behalf of the Participant. In addition the Administrator may, in its sole discretion, employ any other lawful means to recover overpayment on behalf of the Plan. These rights are in addition to any other rights and remedies that the Plan may have.

(g) Attorneys' Fees and Expenses. Neither the Benefit Program nor any Employer will be responsible for any attorneys' fees or expenses incurred in connection with any sums recovered by the Covered Person (or that person's legal representative) from the Third Party; provided, however, that if the Administrator has consented to the retention of the Covered Person's attorney, the total amount for which the Covered Person is liable will not exceed his or her recovery net of all legal fees and expenses.

Section 12.04 Recovery of Benefit Overpayment. If any benefit from a Benefit Program paid to or on behalf of a Covered Person should not have been paid or should have been paid in a lesser amount, and the Covered Person or other recipient fails to repay the amount promptly, then the overpayment may be recovered by the Administrator to the extent permitted by law from any monies then payable, or which may become payable, in the form of salary, wages, or benefits payable under any Employer sponsored benefit programs, including the applicable Benefit Program. The Administrator also reserves the right to recover any such overpayment by appropriate legal action.

Section 12.05 Termination of Coverage for False Representations or Fraud. If any individual makes a false representation to, or commits any other fraud under or with respect to, the Plan, the Administrator has the right to permanently terminate coverage for the individual and his or her Dependents to the extent permitted by law. This may include, but is not limited to, submitting falsified claims or obtaining coverage for an individual who is ineligible (for example, adding a spouse before the date of marriage or failing to notify the Plan of a divorce from a covered spouse). Any termination of coverage will generally be effective on a prospective basis. However, in the case of fraud or an intentional misrepresentation of material fact, the individual's coverage may be terminated by the Administrator on a retroactive basis (a "rescission" of coverage), in which case the individual will receive a notice of the rescission, as required by the Affordable Care Act. To the extent permitted by law, the Administrator may also seek reimbursement from the individual for all claims or expenses paid by the Plan as a result of the false representation or other fraud, and may pursue legal action against the individual.

ARTICLE XIII
ADMINISTRATION

Section 13.01 Administration. The Committee shall be the named fiduciary of the Program under ERISA Section 402 to the extent provided in Section 13.03, and the Administrator shall be the named fiduciary in all other respects, except as provided in Section 14.01(b). The Administrator also shall be the "administrator" of the Plan within the meaning of Section 3(16)(A) of ERISA.

The Plan shall be interpreted by the Committee. Subject to the provisions of the Plan including, but not limited to, the second paragraph of Section 13.05, the actions and determinations of the Committee and the interpretation and construction of any provision of the Plan by the Committee shall be final and conclusive upon all individuals or entities affected thereby.

The Committee and the Administrator may delegate certain responsibilities under the Plan to persons or entities. Following such delegation, any references in this document or in the Program Documents to the Committee or Administrator shall be construed as references to such persons or entities, as applicable.

Section 13.02 Settlor Activities. The Company reserves the right to modify or amend the Plan, including any Appendix hereto, in any respect, at any time and from time to time, retroactively or otherwise, as set forth in Section 15.01. Notwithstanding anything in this document to the contrary, the Committee shall also have the authority and be empowered to adopt amendments to the Plan (other than amendments affecting the Plan's governance provisions), including amendments to: (i) select, appoint, review, remove or replace any trustee, Insurance Company, or other entity related to the administration of the Plan; (ii) modify rules governing eligibility to participate in any Benefit Program; or (iii) permit an Affiliate to participate in the Plan or cease an Affiliate's participation in the Plan upon such terms and conditions deemed appropriate. The Committee has delegated its authority and has empowered the Company's Chief Human Resources Officer to amend the Plan. The Committee, in its capacity as the settlor of the Plan, shall not be acting in a fiduciary capacity with respect to eligibility for, Benefit Programs under or features of the Plan.

Section 13.03 Committee Responsibilities. In addition to the rights, powers, and duties assigned to it elsewhere in the Plan, the Committee (or its delegate) shall have such authority and discretion as may be necessary or desirable to discharge its responsibilities under the Program including, but not limited to, the following rights, powers and duties (provided that the Committee shall not be responsible for any responsibility allocated to an Affiliate or Insurance Company):

(a) with respect to Benefit Programs, to determine a person's status as a Covered Person or his or her right or entitlement to a benefit under the Plan; to afford any person dissatisfied with such determination the right to a hearing thereon; and to direct payments in accordance with the provisions of the Plan;

(b) to construe and interpret the Plan, to make findings of fact, to remedy ambiguities, inconsistencies or omissions and to have full discretionary authority and control over the Program subject, however, to Section 13.05;

(c) to take all other steps the Committee deems necessary or desirable to properly administer the Plan in accordance with its terms and the requirements of applicable law; and

(d) to employ any third party administrators, claims administrators, advisors, agents, attorneys, accountants or other persons (who also may be employed by the Company or an Affiliate) and to allocate or delegate to them such powers, rights and duties as the Committee considers necessary or advisable to properly.

The decisions of the Committee shall be final and binding on all parties including, but not limited to, Employers, Employees, Covered Persons and their Dependents, heirs, distributees and personal representatives, and any other person claiming an interest under the Plan.

The Committee has delegated its authority with respect to Section 13.03(d) above to the Chief Human Resources Officer. The Committee may further delegate such Committee responsibilities described in this Section 13.03 to the extent provided in The Hertz Benefits Committee Charter.

Section 13.04 Administrator Responsibilities. In addition to the rights, powers and duties assigned to it elsewhere in the Plan, the Administrator (or its delegate) shall have such authority and discretion as may be necessary or desirable to discharge its responsibilities under the Plan including, but not limited to, the following rights, powers, and duties:

(a) to direct all Compensation reductions under the Plan;

(b) to accept, modify or reject Plan elections for reasons of eligibility or non-discrimination;

(c) to make appropriate adjustments as to amounts mistakenly paid from the Plan and to make appropriate adjustments to ensure that Covered Persons receive the proper amount from the Plan;

(d) to adopt such rules of procedure as may be appropriate for the administration of the Plan and as are consistent with its terms, including, but not limited to, promulgating enrollment, election and claim forms to be used by Employees and Covered Persons and establishing procedures and deadlines for the filing of enrollment, election and claim forms;

(e) to enroll Participants in the Plan, to distribute and receive Plan administration forms, to comply with all applicable governmental reporting and disclosure requirements, and to prepare and distribute, in such manner as the Administrator deems appropriate, information explaining the Plan;

(f) to carry out the administration of the Program, provided that any such allocation or delegation and the acceptance thereof shall be in writing;

(g) to maintain or cause to be maintained appropriate records concerning the operation and administration of the Plan;

(h) to establish a written procedure, as described in ERISA Section 609(a)(5), for determining whether medical child support orders are qualified and to make determinations thereunder; and

(i) to take all other steps the Administrator deems necessary or desirable to properly administer the Plan in accordance with its terms and the requirements of applicable law.

The Administrator may delegate certain of its responsibilities under the Plan. Notwithstanding anything to the contrary, the Administrator shall have no authority with respect to the rights, powers and duties assigned to the Committee (except as delegated to it by the Committee).

Section 13.05 Delegation of Fiduciary Responsibility. The Committee is a fiduciary with respect to the Plan solely to the extent of its responsibilities specified in this Plan document and subject to the responsibilities of the Company as the Administrator. The Committee shall exercise all discretionary authority and control with respect to management of the Plan that is not specifically granted to a claims administrator, another fiduciary or reserved to the Company as settlor of the Plan. References in the Plan documents to determinations made by the Committee are deemed to include determinations made by a claims administrator, the Administrator or another fiduciary to whom the Committee has granted the relevant authority or control.

The Committee may delegate certain of its fiduciary responsibilities under the Plan to persons or entities who are not named fiduciaries of the Plan. If another person or entity is so appointed by the Committee, references in this document or in the SPD(s) to the Committee shall be construed as references to such person or entity. Notwithstanding Section 13.03, in any situation where benefits under the Plan or a Benefit Program are provided through an Insurance Company, the Committee hereby delegates to the Insurance Company all of the Committee's powers and duties relating to the interpretation and construction of that Insurance Company Benefit Program and making determinations thereunder, and such Insurance Company is hereby deemed to have accepted such delegation. In such case, the Insurance Company shall be the "named fiduciary" for purposes of such benefits, as permitted under 29 C.F.R. §2560.503-1(g).

Section 13.06 Limitations on Fiduciary Responsibility. Each fiduciary of the Plan shall be solely responsible for its own acts or omissions. Except to the extent required by ERISA, no fiduciary shall have the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon such other fiduciary by federal or state law. No fiduciary shall have any liability for a breach of fiduciary responsibility of another fiduciary with respect to the Plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach, fails to take reasonable remedial action to remedy such breach or, through its negligence in performing its own specific fiduciary responsibilities which give rise to its status as a fiduciary, it enables such other fiduciary to commit a breach of the latter's fiduciary responsibility.

No fiduciary shall be liable with respect to a breach of fiduciary duty if such breach is committed before it became a fiduciary or after it ceases to be a fiduciary and nothing in this Program shall be deemed to relieve any person from liability for its willful misconduct or fraud.

Pursuant to the second paragraph of Section 13.05, certain powers and duties have been delegated to Insurance Companies for Benefit Programs. The circumstances for which the Employers and the Committee shall not be responsible, nor shall they be liable for instituting action in connection with, include, but are not limited to, the following:

(a) the validity of provisions of such Insurance Company Program Documents;

(b) failure or refusal by such an Insurance Company to provide benefits under such a Program Document;

(c) an act by a person which may render such a Program Document invalid or unenforceable; or

(d) inability to perform or delay in performing an act, which inability or delay is occasioned by a provision of such Program Document or a restriction imposed by such an Insurance Company.

If any Benefit Programs are self-insured by the Employers, the Committee shall not be responsible for, nor shall they be liable for, instituting action in connection with any failure of the Employers to provide any portion of those Benefit Programs. Claims administrators engaged by the Committee or the Administrator process claims and do not warrant that any benefits to Covered Persons under the Benefit Program will be paid. Complete and proper claims for benefits made by Covered Persons to a claims administrator will be promptly processed in accordance with the claims procedures.

In the event of a delay in processing, a Covered Person shall have no greater right or interest or other remedy against the Claims Administrator than otherwise afforded by law.

Section 13.07 Exercise of Committee's Duties. The Committee shall discharge its duties hereunder solely in the interests of the Participants and other persons entitled to benefits under the Plan, for the exclusive purpose of providing benefits to Participants and other persons entitled to benefits thereunder, and with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims. A member of, or an individual appointed to act on behalf of, the Committee may not decide or determine any matter or question relating solely to his or her own benefits under the Plan unless such decision could be made by him or her under the Plan if he or she were not a member or appointee of the Committee, or unless he or she is the only member of the Committee.

Section 13.08 Committee Expenses. No remuneration shall be paid by the Plan to any Committee member or individual appointee already receiving compensation from the Company or an Affiliate. However, the expenses of the Committee members and appointees (including the fees and expenses of any person employed by them in accordance with this Article XIII) and incurred in the performance of a Committee function shall be reimbursed by the Employers, if they choose to do so, or, if not reimbursed by the Employers, treated as an administrative expense of the Plan payable by application of forfeitures under the Plan or, in the discretion of the Committee, by use of any refund, rebate, other cost reduction or any demutualization proceeds received by or credited to the Plan.

Section 13.09 Reliance on Information. The Administrator and the Committee shall be entitled, to the maximum extent permitted by law, to rely conclusively on all information regarding personnel, tables, valuations, certifications, opinions and reports furnished by the Company, an Affiliate, counsel, consultants, advisers, Insurance Companies or any other person employed or engaged by the Administrator, the Committee, the Company or an Affiliate.

Section 13.10 Appropriate Forms. To the extent that the Administrator prescribes forms for use by Employees in communicating with the Employers, the Committee or an Insurance Company, as the case may be, or establishes periods during which communications may be received, the Administrator shall be protected in disregarding, respectively, any notice or communication for which a form shall so have been prescribed and which shall not be made in such form, and any notice or communication for the receipt of which a period shall so have been established and which shall not be received during such period. The Administrator also shall be protected in, respectively, acting upon any notice or other communication purporting to be signed by any person and reasonably believed to be genuine and accurate, or accepting any notice or communication which shall not be on the proper form or shall not be received during the proper period, and shall not be deemed imprudent by reason of so doing.

Section 13.11 Records and Reports. The Administrator will maintain such records of its activities and of Participants and operations as it deems necessary and appropriate. Plan records pertaining to the Company, the Employers or Employees (subject to any privacy and confidentiality protections required by law or established by the Administrator's rules) will be available for examination by the Company at reasonable times during normal business hours. The Administrator's Plan records pertaining to a Participant will be available for examination by such Participant upon written request at reasonable times during normal business hours.

To the extent required by applicable law, the Administrator will provide each eligible Employee from time to time with a written explanation of the Plan in form and substance sufficient to satisfy the summary plan description requirements of Department of Labor Regulations Sections 2520.102-2 through 2520.102-4. Upon written request, the Administrator will furnish a Participant (or beneficiary) with a copy of the latest updated summary plan description, the latest annual report, any trust agreement, contract, or other instrument under which the Plan is established or operated, within 30 days of the request.

The Administrator will make such reports to the Company as it will reasonably request, and such reports to government authorities as applicable law will require.

ARTICLE XIV
CLAIMS ADMINISTRATION

Section 14.01 General. All claims for benefits under the Plan will be submitted in writing to and decided by such persons or organizations as the Committee may from time to time designate, in the form and within the time specified by the Committee. Benefits under the Plan will be paid only if the Committee decides in its sole discretion that the Claimant is entitled to them. The Committee's decisions made pursuant to this Section are intended to be final and binding on Participants, beneficiaries and others. For purposes of this Article X, the Committee has delegated its discretionary authority to grant or deny benefits under the Plan to the Chief Human Resources Officer. The Committee may further delegate its authority and responsibilities under this Article to a Claims Administrator. Any reference to the Committee or Chief Human Resources Officer in this Article will mean the applicable Claims Administrator, if the relevant authority and responsibility has been delegated to that Claims Administrator, and in the case of insured arrangements, shall mean the Insurance Company.

(a) Applicable Procedures. For all Health Care Claims, the expedited claims procedures set forth in Section 14.03 will apply. For disability claims, the claims procedures set forth in Section 14.04 will apply. For all other claims filed under the Plan, the claims procedures set forth in Section 14.05 will apply. Notwithstanding the foregoing, to the extent that the Committee properly delegates its claims authority to a Claims Administrator, the Claims Administrator may apply alternative time frames than that set forth in this Article. In such circumstance, such alternative time frames will control. In any case, each claims procedure set forth in this Article or applied by the Claims Administrator is intended to comply with Department of Labor Regulations Section 2560.503-1.

(b) Insured Programs. Notwithstanding any provision of this Plan to the contrary, to the extent that an Insurance Company (or other Claims Administrator) administers claims under a Benefit Program, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such Insurance Company or Claims Administrator. The Insurance Company will determine claims related to eligibility only to the extent eligibility depends on an insurance requirement, such as evidence of insurability. In such cases, the Insurance Company or other Claims Administrator will have discretionary authority to decide such claims under this Section 14.01 and will be the "named fiduciary" for purposes of such Benefit Program, as permitted under Department of Labor Regulations Section 2560.503-1(g).

(c) Authorized Representatives. A Claimant may designate an authorized representative to act on Claimant's behalf in pursuing a benefit claim or appeal of an adverse benefit determination. The Claimant may specify the purposes for which the authorized representative may act on its behalf. In order to designate an authorized representative, a Claimant must complete all forms required by the Committee and follow all procedures established by the Committee. Upon receipt and approval of all necessary forms, the Committee will direct all information and notification to which the Claimant is otherwise entitled with respect to the aspect of the claim or appeal specified by the Claimant.

Section 14.02 Processing of Claims. Unless a Program Document provides for a shorter period, all claims must be submitted within one year after the date the claim accrues. The

Committee will process a claim promptly after it receives complete written proof of the claim. The Committee may process an Urgent Care Claim without a complete written proof of claim, provided that any benefit paid is conditioned upon the Committee receiving a complete written proof of claim within a reasonable period of time thereafter. If the Committee finds that benefits are payable under the Plan, it will send payment to the Claimant, unless such individual authorizes payment to be made directly to the provider of services or supplies.

Section 14.03 Health Care Claims.

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

(i) "Concurrent Care Claim" means a Health Care Claim to extend an ongoing course of treatment beyond the period of time or number of treatments authorized by the Committee.

(ii) "Health Care Claim" means a request by a Claimant for a benefit under a Benefit Program that is a group health plan (i.e., an employee welfare benefit plan within the meaning of ERISA Section 3(1) to the extent that such plan provides "medical care" within the meaning of ERISA Section 733(a)) that is made in accordance with the rules and procedures established by the Committee.

(iii) "Post-Service Claim" means a Health Care Claim that is not a Pre-Service Claim, Urgent Care Claim or Concurrent Care Claim.

(iv) "Pre-Service Claim" means a Health Care Claim with respect to which the terms of a Benefit Program condition receipt of the benefit, in whole or in part, on approval of the benefit by the Committee in advance of obtaining medical care.

(v) "Urgent Care Claim" means a Health Care Claim for medical care not yet performed but, if delayed:

(A) could seriously jeopardize the Claimant's life, health or the ability to regain maximum function; or

(B) in the opinion of a physician who has knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or medical treatment for which the Claimant is filing the claim.

(b) Time Limits for Initial Claims. Any person who believes that he is then entitled to receive a health care benefit under the Plan, including one greater than that initially determined by the Committee, may file a Health Care Claim in writing with the Committee. The Committee will notify a Claimant of its benefits determination, depending on the type of claim, within a specific time period, as set forth in this subsection.

(i) Urgent Care Claim: The Committee will provide notice of the Plan's benefit determination to a Claimant as soon as possible, but no later than 72 hours after the Plan receives an Urgent Care Claim. However, if the Claimant does not follow the Plan's claims procedure or does not provide sufficient information with a claim, the Committee will notify the Claimant of the deficiency as soon as possible, but not later than 24 hours after receiving the claim. Such notice will describe the proper claims procedure and/or the specific information necessary to complete the Urgent Care Claim. If an Urgent Care Claim is incomplete or the Committee requires more information, a Claimant will have at least 48 hours to provide the specified information. In the case of an incomplete initial claim, the Committee will notify a Claimant of its benefits determination no later than 48 hours after the earlier of:

(A) the time the Committee receives the specified information; or

(B) the end of the period in which a Claimant was allowed to provide the required information.

(ii) Pre-Service Claim (Not Involving An Urgent Care Claim): The Committee will notify a Claimant of a Plan's benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Committee receives a Pre-Service Claim (or such shorter period applicable in the event a second level of appeal is available). The Committee may extend this 15-day period one time for up to 15 days, if the Committee determines that more time is necessary due to matters beyond the Plan's control. The Committee will notify a Claimant before the end of the initial 15-day period if an extension is necessary. If the extension is necessary because a Claimant did not submit required information, the Committee will, in the notice, specifically describe the required information and will provide the Claimant with an additional 45 days to provide the information. In this case, the time period allowed for making the benefits determination is tolled from the date the notice is sent to the Claimant until the date the Claimant responds to the notice. If the Claimant does not follow the Plan's claims procedure, the Committee will notify the Claimant as soon as possible, but not later than five calendar days after receiving the Pre-Service Claim. The notice will describe the proper procedure for filing the Pre-Service Claim.

(iii) Concurrent Care Claim: For a Concurrent Care Claim relating to Urgent Care, the Committee will notify a Claimant as soon as possible, taking into account the medical exigencies, but generally no longer than 24 hours, provided that any such claim is made to the Plan at least 24 hours before the prescribed period of time or number of treatments expires. For a Concurrent Care Claim relating to non-Urgent Care, the Committee will notify a Claimant sufficiently in advance of the reduction or termination of the

Claimant's treatment to allow a Claimant to appeal and obtain a review of the Concurrent Care Claim before the treatment is reduced or terminated.

(iv) Post-Service Claim: The Committee will notify a Claimant of a Plan's benefit determination not later than 30 days after the Committee receives a Post-Service Claim (or such shorter period applicable in the event a second level of appeal is available). If the Committee determines that more time is necessary due to matters beyond the Plan's control, the Committee may extend this 30-day period one time, for up to 15 days. The Committee will notify a Claimant before the end of the initial 30-day period if an extension is necessary. If the extension is necessary because a Claimant did not submit required information, the Committee will specifically describe the required information and will provide a Claimant with an additional 45 days to provide the information. In this case, the time period allowed for making the benefits determination is tolled from the date the notice is sent to a Claimant until the date the Claimant responds to the notice.

(c) Notice of Initial Denial. The Committee's denial of a claim will be written in a manner calculated to be understood by the Claimant and will include:

(i) the specific reason or reasons for the benefit determination;

(ii) information sufficient to specifically identify the claim involved (including denial codes);

(iii) references to specific Plan provisions on which the benefit determination is based;

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

(v) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim;

(vi) an explanation of the appeal procedure;

(vii) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy will be furnished (free of charge) upon request;

(viii) if the decision was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to the Claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;

(ix) a statement disclosing the availability of, and contact information for, any applicable consumer assistance office or ombudsman established to assist individuals with claims and appeals questions; and

(x) a statement that the Claimant has the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

(d) Claimant's Right to Appeal. A Claimant (or his duly authorized representative) whose claim is denied in whole or in part by the Committee may, within 180 days after receipt of denial of his claim or, if no notice of denial was received, within 180 days of the date the notice should have been provided:

(i) submit a written request for review by the Committee;

(ii) receive reasonable access to, copies (free of charge) of all documents, records and other information relevant (within the meaning of Department of Labor Regulation Section 2560.503-1(m)(8)) to the Claimant's claim; and

(iii) submit written comments, documents, records and other information relating to the claim for benefits.

(e) Independent Review. The review of the initial decision concerning a Claimant's claim must be performed by someone who is neither the original decision maker nor the subordinate of the original decision maker. In reviewing the initial decision, the decision maker must not give any deference to the initial decision and he must consider all information relevant to the claim, not just information relied upon (or available) when the original decision was made. The decision maker must also consider any information submitted by the Claimant.

If the benefit determination is based in whole or in part on a medical judgment, the decision maker reviewing the claim will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment issue; provided that such health care professional will be an individual who is neither an individual who was consulted in the connection with the initial claim denial that is the subject of the appeal nor the subordinate of any such individual. The Plan will disclose to the Claimant the identity of medical or vocational experts whose advice was obtained by the Plan in connection with the review, even if the advice was not relied upon in making the final decision.

The decision maker will also provide the Claimant, free of charge, any new or additional evidence considered, relied upon, or generated in connection with the Claimant's appeal. In addition, before the Claimant receives an adverse benefit determination on review based on a new or additional rationale, the decision maker will provide the Claimant, free of charge, with the rationale.

(f) Time Limits for Decision on Appeal. The Committee will furnish the Claimant with a written decision providing the final decision concerning the claim as soon as practicable from the date of the request for appeal was submitted, but not later than:

(i) 72 hours after receipt of the Claimant's request for review of an Urgent Care Claim benefit determination;

(ii) 30 days (or 15 days in the event the Committee offers two levels of appeal) after receipt by the Plan of the Claimant's request for review of a Pre-Service Claim benefit determination; or

(iii) 60 days (or 30 days in the event the Committee offers two levels of appeal) after the receipt by the Plan of the Claimant's request for review of a Post-Service Claim benefit determination.

(g) Notice of Decision on Appeal. The final decision concerning an appeal of a claim will be written in a manner calculated to be understood by the Claimant and will include:

(i) the specific reason or reasons for the benefit determination;

(ii) information sufficient to specifically identify the claim involved (including denial codes);

(iii) references to specific Plan provisions on which the benefit determination is based;

(iv) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim;

(v) an explanation of any voluntary appeal procedures offered by the Plan, if any;

(vi) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy will be furnished (free of charge) upon request;

(vii) if the decision was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to the Claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;

(viii) a statement disclosing the availability of, and contact information for, any applicable consumer assistance office or ombudsman established to assist individuals with claims and appeals questions;

(ix) a statement regarding the availability of external review; and

(x) a statement that the Claimant has the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

(h) Notwithstanding the foregoing, Claimants may not seek benefits under the Plan in judicial or administrative proceedings without first complying with and fully exhausting the procedures set forth in this Section 14.03. In addition, Claimants must bring civil action under ERISA Section 502(a) within two years after the Claimant's initial claim or within six months from the date of the final claim decision on appeal, whichever comes first, or if shorter, the date specified in the Benefit Program (unless a longer period is required by state law). The decisions made pursuant to this Section 14.03 will be final and binding on Claimants and any other party.

(i) External Review. A Claimant may be eligible for independent external review pursuant to federal law after exhausting the internal appeal process.

(i) Eligibility for Review. Except where required by law, external review is only available with respect to adverse benefit determinations involving medical judgment (except claims which only involve interpretation of a contract or law without any use of medical judgment) or a rescission of coverage.

(ii) Request for Review. A Claimant must file a request for external review within four months after the date the Claimant receives notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(iii) Preliminary Review. Within five business days after receiving a Claimant's request for external review, the decision maker will complete a preliminary review of the request to determine:

(A) Whether the Claimant is or was covered under the Benefit Program at the time the health care item or service was requested or provided;

(B) Whether the Claimant was eligible to participate in the Benefit Program and if the adverse benefit determination was related to that;

(C) Whether the Claimant exhausted the Benefit Program's internal appeal process or if the Claimant was deemed to have exhausted the internal appeals process; and

(D) Whether the Claimant provided all the information and forms required to process an external review.

The decision maker will notify Claimants in writing of its findings within one business day after completing this preliminary review. If a Claimant's request is complete but not eligible for external review, the Claimant will be notified of the reasons for its ineligibility and will be given contact information for the Employee Benefits Security Administration. If the Claimant's request is not complete, the

Claimant will be informed of the information or materials needed to make the request complete. The Claimant will have not less than 48 hours or the remaining time in the four month filing period to provide this information - whichever is longer.

(iv) Referral to Independent Review Organization. The Benefit Program will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. The IRO will determine if the adverse benefit determination involves medical judgment.

(v) Request for Expedited External Review. For Pre-Service Claims involving urgent/concurrent care, a Claimant may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Plan's internal appeal process.

Section 14.04 Disability Claims.

(a) Time Limits for Initial Claims. Any person who believes that he is then entitled to receive a disability benefit under the Plan, including one greater than that initially determined by the Committee, may file a claim in writing with the Committee. The Committee (or his or her designee) will, within 45 days of the receipt of a claim, either grant or deny the claim in writing. An extension of 30 days will be allowed for processing the claim if necessary due to matters beyond the Plan's control and the Claimant receives notice of such extension before the expiration of the initial 45-day period. The notice will state the special circumstances involved and the date a decision is expected. If, before the end of the first 30-day extension period, the Committee 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 the Committee notifies the Claimant before the expiration of the first 30-day extension period of the circumstances requiring the additional extension and the date as of which the Plan expects to render a decision. In the case of any extension under this subsection (a), the notice of extension will specifically explain the standards on which the 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 the Claimant will be afforded at least 45 days within which to provide the additional information. If additional information is requested to resolve the issues, the time period allowed for making the benefits determination is tolled from the date the notice is sent to a Claimant until the date the Claimant responds to the notice.

(b) Notice of Initial Denial. The Committee's denial of a claim will be written in a culturally and linguistically appropriate manner, calculated to be understood by the Claimant and will include:

(i) the specific reason or reasons for the benefit determination;

(ii) references to specific Plan provisions on which the benefit determination is based;

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

(iv) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim;

(v) an explanation of the appeal procedure;

(vi) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy will be furnished (free of charge) upon request;

(vii) if the decision was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to the Claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;

(viii) for claims submitted on or after April 1, 2018, a discussion of the decision including an explanation of the basis for disagreeing with or not following: (i) the views presented to the Plan of health care professionals treating the Claimant or vocational professionals who evaluated the Claimant; (ii) the views of the medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a Social Security Administration disability determination presented by the Claimant to the Plan; and

(ix) a statement that the Claimant has the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

(c) Claimant's Right to Appeal. A Claimant (or his duly authorized representative) whose claim is denied in whole or in part by the Committee may, within 180 days after receipt of denial of his claim or, if no notice of denial was received, within 180 days of the date the notice should have been provided:

(i) submit a written request for review by the Committee;

(ii) receive reasonable access to, copies (free of charge) of all documents, records and other information relevant (within the meaning of Department of Labor Regulation Section 2560.503-1(m)(8)) to the Claimant's claim;

(iii) for claims submitted on or after April 1, 2018, receive (free of charge) as soon as possible and sufficiently in advance of the date on which a notice of adverse benefit determine on review is required to be provided, any new or additional evidence considered, relied upon, or generated in connection

with the Claimant's claim and any new or additional rationales forming the basis of the Plan's determination of the Claimant's claim; and

(iv) submit written comments, documents, records and other information relating to the claim for benefits.

(d) Independent Review. The review of the initial decision concerning a Claimant's claim must be performed by someone who is neither the original decision maker nor the subordinate of the original decision maker. In reviewing the initial decision, the decision maker must not give any deference to the initial decision and he will consider all information relevant to the claim, not just information relied upon (or available) when the original decision was made. The decision maker will also consider any information submitted by the Claimant.

If the benefit determination is based in whole or in part on a medical judgment, the decision maker reviewing the claim will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment issue; provided that such health care professional will be an individual who is neither an individual who was consulted in the connection with the initial claim denial that is the subject of the appeal nor the subordinate of any such individual. The Plan will disclose to the Claimant the identity of medical or vocational experts whose advice was obtained by the Plan in connection with the review, even if the advice was not relied upon in making the final decision.

(e) Time Limits for Decision on Appeal. The Committee will furnish the Claimant with a written decision providing the final determination of the claim. The decision will be issued as soon as reasonable after the date the request for appeal was submitted, and usually within 45 days of the date in which the written appeal was submitted. The Committee may take an additional 45 days to make this decision if special circumstances are present. The Committee will give the Claimant notice if this extension is necessary before expiration of the initial 45-day period. In no event will such extension exceed a period of 45 days from the end of the initial 45-day 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.

(f) Notice of Decision on Appeal. The decision concerning an adverse decision on appeal will be written in a culturally and linguistically appropriate manner, calculated to be understood by the Claimant and will include:

(i) the specific reason or reasons for the benefit determination;

(ii) references to specific Plan provisions on which the benefit determination is based;

(iii) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim;

(iv) an explanation of any voluntary appeal procedures offered by the Plan, if any;

(v) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy will be furnished (free of charge) upon request;

(vi) if the decision was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to the Claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;

(vii) for claims submitted on or after April 1, 2018, a discussion of the decision including an explanation of the basis for disagreeing with or not following (i) the views presented to the Plan of health care professionals treating the Claimant or vocational professionals who evaluated the Claimant; (ii) the views of the medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a Social Security Administration disability determination presented by the Claimant to the Plan; and

(viii) a statement that the Claimant has the right to bring civil action under ERISA Section 502(a) following a denial upon appeal and a description of any applicable Plan-imposed limitations period, including the calendar date when the limitations period will expire.

(g) Notwithstanding the foregoing, Claimants may not seek benefits under the Plan in judicial or administrative proceedings without first complying with and fully exhausting the procedures set forth in this Section 14.04. In addition, Claimants must bring civil action under ERISA Section 502(a) within two years after the Claimant's initial claim or within six months from the date of the final claim decision on appeal, whichever comes first, or if shorter, the date specified in the Benefit Program. The decisions made pursuant to this Section 14.04 are final and binding on Claimants and any other party.

Section 14.05 All Other Claims.

(a) Time Limits for Initial Claims. Any person who believes that he or she is then entitled to receive a benefit under the Plan, including one greater than that initially determined by the Committee, may file a claim in writing with the Committee. The Committee (or his or her designee) will, within 90 days of the receipt of a claim, either grant or deny the claim in writing. An extension of 90 days will be allowed for processing the claim if special circumstances are involved and the Claimant is notified of such extension before the expiration of the initial 90-day period. The notice will state the special circumstances involved and the date a decision is expected. If no notice is received during that period, the claim will be deemed denied and the Claimant may request a review of the decision.

(b) Notice of Initial Denial. The Committee's denial of a claim will be written in a manner calculated to be understood by the Claimant and will include:

(i) the specific reason or reasons for the benefit determination;

(ii) references to specific pertinent Plan provisions on which the benefit determination is based;

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

(iv) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant (within the meaning of Department of Labor Regulation 2560.503-1(m)(8)) to the Claimant's claim;

(v) an explanation of the appeal procedure; and

(vi) a statement that the Claimant has the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

Notwithstanding the foregoing, if the Committee does not timely respond to a claim in writing, the claim will be deemed denied.

(c) Claimant's Right to Appeal. A Claimant (or his duly authorized representative) whose claim is denied in whole or in part by the Committee may, within 60 days after receipt of denial of his claim:

(i) submit a written request for review by the Committee;

(ii) receive reasonable access to, copies (free of charge) of all documents, records and other information relevant (within the meaning of Department of Labor Regulation Section 2560.503-1(m)(8)) to the Claimant's claim; and

(iii) submit written comments, documents, records and other information relating to the claim for benefits.

(d) Time Limits for Appeal. The Committee will furnish the Claimant with a written decision providing the final determination of the claim. The decision will be issued as soon as reasonable after the date the request for appeal was submitted, and usually within 60 days of the date in which the written appeal was submitted. The Committee may take an additional 60 days to make this decision if special circumstances are present. The Committee will give the Claimant notice if this extension is necessary before termination of the initial 60-day period. The notice will state the special circumstances involved and the date a decision is expected. In no event will such extension exceed a period of 60 days from the end of the initial 60-day period.

(e) Notice of Appeal. The decision concerning an appeal of a claim will be written in a manner calculated to be understood by the Claimant and will include:

(i) the specific reason or reasons for the denial;

(ii) references to specific Plan provisions on which the benefit determination is based;

(iii) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant (within the meaning of Department of Labor Regulation 2560.503-1(m)(8)) to the Claimant's claim;

(iv) an explanation of the voluntary appeal procedures offered by the Plan, if any, and

(v) a statement that the Claimant has the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

Section 14.06 Exhaustion of Administrative Remedies. Claimants will not be entitled to challenge the Committee's determinations in judicial or administrative proceedings without first complying with the administrative claims procedures set forth in the applicable Program Document or under this Article, as appropriate. All such claims must be brought within the timeframes set forth above for the Claimant's type of claim. The decisions made pursuant to applicable administrative claims procedures are final and binding on the Claimant and any other party. A Claimant may, however, seek an external review if his claim meets the conditions set forth in this Article. If the Claimant has complied with and exhausted the appropriate claims procedures and intends to exercise his right to bring civil action under ERISA Section 502(a), the Claimant must bring civil action under ERISA Section 502(a) within one year from the date of the final claim decision on appeal (or voluntary appeal, if offered and the Claimant files a voluntary appeal), or if shorter, the date specified in the Benefit Program (unless a longer period is required by state law). If the Claimant does not bring such action within such period, the Claimant will be barred from bringing an action under ERISA related to his claim.

Section 14.07 Forum Selection. Any legal action (whether in law, in equity or otherwise) must be brought in the U.S. District court of the federal district court whose jurisdiction includes Lee County, Florida, where the Plan is administered. Each Participant, Covered Person, Claimant or other person consents and submits to the personal jurisdiction over him or her of the federal district court whose jurisdiction includes Lee County, Florida in respect of any such action(s) or litigation. Each Participant, Covered Person, Claimant or other person consents to service of process upon him or her with respect to any such action(s) or litigation by registered mail, return receipt requested, and by any other means permitted by rule or law.

Section 14.08 Incompetency. If any person entitled to payments under the Benefit Programs is a minor or under other legal disability or otherwise incapacitated so as to be unable to manage his or her financial affairs, or is otherwise incapable of giving a valid receipt and discharge for any payment, the following provision will apply. If the payment is to be made by an Insurance Company, such payment will be made in accordance with the terms of the contract under which such benefit is payable. If the payment is to be otherwise made, the Committee, in its discretion, may direct that all or any portion of such payment be made:

(a) to such person;

(b) to such person's legal guardian or conservator; or

(c) to such person's Spouse or to any other person,

in any manner the Committee considers advisable, to be expended for his or her benefit. The decision of the Committee (or, where applicable, that of the Insurance Company) will, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred will operate as a complete discharge of the obligations of the Benefit Programs, the Company, the Employers, the Committee, and any Insurance Company, with respect to such payment.

ARTICLE XV
AMENDMENT AND TERMINATION

Section 15.01 Amendment. The Company reserves the discretionary right to modify or amend the Plan, or any Appendix or Benefit Program hereto, in any respect, at any time and from time to time, retroactively or otherwise, as designated by a written instrument adopted by the Compensation Committee of the Board of Directors or its designee and duly executed on behalf of the Company. Notwithstanding anything in this document to the contrary, the Committee shall also have the authority and be empowered to adopt amendments to the Plan (other than amendments affecting the Plan's governance provisions). The Committee has delegated its authority with respect to amendment of the Plan to the Chief Human Resources Officer. Such amendment shall be binding on any Employers without further action. However, no Plan amendment will be valid which would cause the Plan to fail any applicable qualification requirements of Sections 79, 105, 125, 129 or 223 of the Code, or any successors thereto, so long as such statutes apply to this Plan. The Committee (or its delegate) will have the right to amend any provision of the Plan that is administrative, procedural, or ministerial in nature, and any written policy, rule, procedure or similar action adopted by the Committee (or its delegate) that is inconsistent with any administrative, procedure or ministerial provision of the Plan will be deemed an amendment.

This Plan or any Benefit Programs may be amended, modified, suspended or terminated retroactively where deemed by the Committee to be necessary or desirable to comply with applicable laws including, without limitation, applicable sections of the Code or ERISA or where deemed by the Committee to be necessary or desirable and not proscribed by applicable laws, subject to the terms of any applicable collective bargaining agreement but only as to the effect of any retroactive amendment, modification, suspension or termination on Covered Persons whose participation in the Plan arises from such bargaining agreement. Except as may be required by applicable law or an applicable collective bargaining agreement, any retroactive amendment, modification, suspension or termination may take effect without any prior notification to Affiliates, Employees, Covered Persons, retirees, Dependents, their heirs and beneficiaries or unions.

Section 15.02 Termination of the Plan. The Company reserves the right to terminate the Plan or any Benefit Program at any time as designated by a written instrument adopted by the Compensation Committee of the Board of Directors or its designee and duly executed on behalf of the Company. Upon termination of the Plan, the Committee will direct the Administrator (or its delegate) to either restore any unused Account balances to the Compensation of each respective Participant or to continue to apply such balances towards Participants' benefits in accordance with Articles VII and VIII for the remainder of the Plan Year, subject to forfeiture thereafter.

ARTICLE XVI
PARTICIPATING EMPLOYERS

Section 16.01 Adoption of Plan. An Affiliate may become an Employer and commence participating in the Plan, subject to the provisions of this Article XVI. For an Affiliate to become an Employer, the Committee must approve the Affiliate's adoption of the Plan as an Employer and specify the date of such adoption. The name of any Affiliate that commences participation in the Plan may be recorded by action of the Committee and included on Appendix B, which Appendices may be appropriately modified from time to time by the Administrator or its delegate to reflect any change in the current Employers. Unless the Committee determines otherwise, an Employer shall automatically cease to be an Employer upon the cessation of its status as an Affiliate.

Section 16.02 Administration. As a condition to adopting the Plan, and except as otherwise provided herein, each Employer will be deemed to have authorized the Committee and the Administrator of the Plan to act for it in all matters arising under or with respect to the Plan and will comply with such other terms and conditions as may be imposed by the Committee and the Administrator.

Section 16.03 Committee and Company as Agent for Employers. Each Affiliate that becomes an Employer, by doing so, appoints the Committee and the Company as its agent to exercise on its behalf all of the powers and authorities conferred upon the Committee and the Company by the terms of the Plan, including, but not limited to, the power to amend and terminate the Plan. The authority of the Committee and the Company to act as such agent will continue unless and until the Employer terminates participation in the Plan pursuant to Section 16.04.

Section 16.04 Termination. The Committee may terminate the designation of an Affiliate as an Employer, or any Benefit Program with respect to an Employer, effective as of any date. Each Employer, other than the Company, may cease to participate in the Plan or in any Benefit Program with respect to its Participants with the approval of the Committee, by action of its board of directors (or other governing body) or its authorized delegate. The withdrawal of an Employer shall be effective as of the last day of the Plan Year in which the withdrawal occurs, unless the Committee consents to a different effective date.

ARTICLE XVII
HIPAA PRIVACY AND SECURITY

Section 17.01 Privacy Policy Incorporated by Reference. The Hertz Corporation Health Plan HIPAA Privacy Policy (the "Privacy Policy") sets forth the privacy policies and procedures applicable to the Plan. The terms of the Privacy Policy, as amended from time to time, are hereby incorporated by reference. Any defined terms used herein, will have the meaning given to them in the Privacy Policy.

Section 17.02 Permitted Disclosures of PHI. The Plan may disclose a Plan Participant's PHI to an Employer to the extent not inconsistent with the HIPAA regulations, for the following purposes:

(a) The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to a Participating Employer information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(b) The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to an Employer, provided that the Employer requests the Summary Health Information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

(c) The Plan may disclose PHI to an Employer to carry out plan administration functions that the Employer performs, provided the disclosure is consistent with the Privacy and Security Rules.

Section 17.03 Restriction on Plan Disclosure to Employers. Except as otherwise permitted or required by law, the Plan will not disclose PHI to an Employer except upon the Plan's receipt of the Employer's certification that the Employer agrees with the conditions and restrictions in the Privacy Policy, and that the Employer will: (a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that the Employer creates, receives, maintains or transmits on behalf of the Plan; (b) ensure that adequate separation of the Plan and the Employer is established, and that such adequate separation is supported by reasonable and appropriate security measures; (c) ensure that any agents to whom the Employer provides PHI or Electronic PHI received from the Plan agree to implement reasonable and appropriate security measures to protect such Electronic PHI; and (d) report to the Plan any security incident, as defined in 45 C.F.R. § 164.304, about which the Employer becomes aware. The Plan will not disclose PHI to the Employer for the purpose of employment-related actions or decisions.

Section 17.04 Adequate Separation Between the Plan and Employers. The Employers and Plan have adequate separation as is established by the Privacy Policy and the following:

(a) Employees With Access to PHI: The employees or other individuals under the control of the Company who may access PHI received from the Plan are those Responsible Employees set forth in the Privacy Policy.

(b) Use Limited to Plan Administration: The access to and use of PHI by the individuals described in (a), above, is limited to Plan Administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by an Employer for the Plan.

(c) Mechanism for Resolving Noncompliance: If the Plan's Privacy Officer, as set forth in the Privacy Policy, or an Employer determines that any person described in (a), above, has violated any of the restrictions of this Article, then such individual will be disciplined in accordance with the Privacy Policy, including applicable the Employer's disciplinary policies referenced therein.

ARTICLE XVIII
MISCELLANEOUS PROVISIONS

Section 18.01 Limitation of Rights. The establishment, maintenance and provision of the Plan will not be considered or construed: (i) as giving to any Employee any right to continue in the employment of any Employer; (ii) as limiting the right of any Employer to discipline or discharge any of its Employees; (iii) as creating any contract of employment between any Employer and any Employee; or (iv) as conferring any legal or equitable right against the Administrator, the Company, or the Employers.

Section 18.02 Rights to Employer Assets. Except as provided in Articles VII and VIII, all balances reflect general assets of the Employers, and all payments made under this Plan are made from the general assets of the Employers. No Participant will have any right to or interest in any assets of the Employers, except as specifically provided in this Plan. The Administrator will have no liability to any Participant, the Company or any Employer for making any payment or providing any benefit pursuant to this Plan, and will merely direct such payments to be made by the Company in accordance with the Plan.

Section 18.03 No Assignments. Unless specifically permitted by a Program Document, the right of any Participant to receive any benefits under the Plan (including the right to file a lawsuit against the Plan, any Program, the Company, any Participating Employers, the Administrator, or any Plan fiduciary with respect to the Plan) will not be alienable by assignment. The right of any Participant to receive any benefits under the Plan will not be subject to any claims by any creditor of or claimant against the Participant; and any attempt to reach such amounts by any such creditor or claimant, or any attempt by the Participant to confer on any such creditor or claimant any right or interest with respect to such amounts, will be null and void, except as provided in Section 609 of ERISA with respect to QMCSO. The payment of Benefits may be made directly to a service provider who has provided medical care to a Participant or to any other third-party to whom such person is indebted as a convenience to such person, provided that such person shall remain primarily liable at all times with respect to payment for such medical care or other indebtedness and such payment shall not imply an enforceable assignment of benefits or the right to receive such benefits. No Compensation reduction elections or other contributions under this Plan will cause any Employer to be liable for, or subject to, any manner of debt or liability of any Participant.

Section 18.04 Severability. Any provision of the Plan will be severable, so that if any Plan provision is held invalid or unenforceable, such invalid or unenforceable provision will be severed from the Plan and the Plan will operate without regard to such severed provision. In such event, the Plan will be construed and enforced as if such severed provision had not been included herein, to the extent necessary to preserve the status of the Plan as qualified cafeteria plan under Section 125 of the Code.

Section 18.05 No Guarantee of Tax Consequences. The Company makes no commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludible from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. Each Participant is obligated to determine whether each payment under this Plan is

excludible from the Participant's gross income for federal and state income tax purposes, and to notify the Company if the Participant has reason to believe that any such payment is not so excludible.

Section 18.06 Imputed Income; Withholding; Reporting. The relevant Employer shall impute income to a Participant as may be required by applicable tax laws, and the Employers, the Administrator, the Committee or an Insurance Company may withhold or deduct from any payments made under this Plan any federal, state or local withholding or other taxes or charges which they may be required to withhold or deduct under applicable law. The Employers will comply with the applicable requirements of the Affordable Care Act regarding the reporting of the value of "applicable employer-sponsored coverage."

Section 18.07 Writings and Electronic Communications. All notices and other communications with respect to the Plan, including signatures relating to such documentation, may be executed and stored on paper, electronically or in another medium. Any documentation executed or stored electronically shall comply with the Electronic Signatures Act. The Administrator, recordkeeper or other service providers may use telephonic or electronic media to satisfy any notice requirements of the Plan, to the extent permissible under applicable regulations. In addition, a Participant's Plan elections may be provided through telephonic or electronic means, to the extent permissible under applicable regulations. The Administrator and the Plan's recordkeepers or other service providers also may use telephonic or electronic media to conduct Plan transactions such as making benefit claims to the extent permissible under applicable regulations.

Section 18.08 Gender and Number. Except as otherwise clearly indicated by the context, whenever used in the Plan a masculine pronoun will include the feminine and neuter genders, words used in the singular will include the plural, and words used in the plural will include the singular, as circumstances make such meanings applicable.

Section 18.09 Governing Law and Forum Selection. The Plan will be construed in accordance with the laws of the State of Florida (determined without regard to any conflicts of law provisions), to the extent not preempted by federal law. Any legal action (whether in law, in equity or otherwise) must be brought in the federal district court whose jurisdiction includes Lee County, Florida, where the Plan is administered.

Section 18.10 Regulatory References. Any reference herein to a section of the Code of Federal Regulations ("C.F.R.") will mean the cited section as in effect or as such may be amended from time to time, and for which compliance by the Plan is required.

Section 18.11 Headings. All headings and captions used in this Plan are used as a matter of convenience and for reference only, and in no way will they be considered in determining the scope or intent of the Plan or in interpreting or construing any Plan provisions.

IN WITNESS WHEREOF, the Company has caused this duly adopted Plan to be executed below by its duly authorized officer or representative on this 16 day of December, 2019 to be effective as of the Effective Date stated herein.

THE HERTZ CORPORATION

By: _____
Murali Kuppuswamy
Its: Chief Human Resources Officer

APPENDIX A

The following Benefit Programs are consolidated into the Plan:

1. Medical (including Prescription Drug and, with respect to certain Medical Program options, a Health Reimbursement Account)
2. Dental
3. Vision
4. Wellness Program
5. Employee Assistance Program
6. Short Term Disability
7. Long Term Disability
8. Life Insurance (Basic Life and Supplemental Life)
9. Dependent Life Insurance
10. Accidental Death and Dismemberment
11. Adoption Assistance*
12. Business Travel Accident Insurance
13. Legal Services
14. Dependent Care Flexible Spending Account*
15. Healthcare Flexible Spending Account
16. Hospital Indemnity Insurance
17. Accident Insurance
18. Critical Illness Insurance
19. Automobile and Homeowners' Insurance*
20. Pet Insurance*

* Indicates Benefit Programs that are not subject to ERISA.

APPENDIX B

The following entities are participating Employers:

1. The Hertz Corporation
2. Hertz Claims Management Corporation
3. Hertz Local Edition (HLE)
4. DTG Operations, Inc.
5. Donlen Corporation
6. Hertz International