Summary Plan Description

East Tennessee Technology Park Health and Welfare Benefit Plan

(as amended and restated effective January 1, 2016)

Summary Plan Description updated January 1, 2019

This Summary Plan Description ("SPD") summarizes the major features of the benefits program for eligible participants and eligible retirees as of January 1, 2019. You should also refer to any applicable cover letter accompanying this SPD for changes and additions to the SPD.

Prior to 2019, eligible active employees of participating employees were eligible for a wide array of health and welfare benefits under the ETTP Plan. In 2019, each participating employer began providing medical, dental and vision benefits through individual company-sponsored plans, except with respect to a select group of collectively bargained employees. As a consequence, the benefit coverages offered under this ETTP Plan has been reduced. If you are impacted by these changes, please contact your employer for more information regarding your benefits now offered outside this ETTP Plan.

As of January 1, 2019, this SPD applies to eligible employees and eligible retirees at the following companies ("Participating Employers"):

- URS | CH2M Oak Ridge LLC ("UCOR")
- Four Rivers Nuclear Partnership, LLC
- Fluor-BWXT Portsmouth LLC
- Wastren Advantage, Inc. (as a participating subcontractor under Four Rivers Nuclear Partnership, LLC)
- Portsmouth Mission Alliance, LLC

The following companies who are Participating Employers had a status change in the ETTP Plan during 2016 or 2017 as of the date set forth below:

- Portsmouth Mission Alliance, LLC adopted the ETTP Plan as of April 25, 2016
- Wastren-EnergX Mission Support, LLC ("WEMS") ceased participating in the ETTP Plan as of April 24, 2016
- Wastren Advantage Inc. ceased participating in the ETTP Plan as of April 24, 2016 (as a participating subcontractor under WEMS)
- SEC Radcon Alliance ceased participating in the ETTP Plan as of November 27, 2016 (as a participating subcontractor under UCOR)
- CDM Federal Services, Inc. ceased participating in the ETTP Plan as of September 30, 2017 (as a participating subcontractor under UCOR)
- Fluor Federal Services, Inc. ceased participating in the ETTP Plan as of October 19, 2017
- LATA Sharp Remediation Services LLC ceased participating in the ETTP Plan as of October 19, 2017 (as a participating subcontractor under Fluor Federal Services, Inc.)
- Four Rivers Nuclear Partnership, LLC adopted the ETTP Plan as of October 20, 2017
- Wastren Advantage, Inc. adopted (readopted) the ETTP Plan as of October 20, 2017 (as a participating subcontractor under Four Rivers Nuclear Partnership, LLC)

You should not rely on the information in this SPD other than as a general summary of the features of the East Tennessee Technology Park Health and Welfare Benefit Plan (the "ETTP Plan").

This SPD is based on legal documents (such as plan documents, insurance contracts, certificates of coverages, summary insurance booklets, and insurance contracts) currently in effect. These documents provide further detail on coverage benefits as well as important exclusions, limitations, and requirements applicable to receive benefits. You may obtain a copy of any of the official legal documents for your coverages by contacting the Plan Administrator at the contact information listed at the end of this SPD in the "General Information".

While every effort has been made to give you correct and complete information about your benefits, in the event of any conflict or inconsistency between this SPD and relevant legal documents with respect to benefits payable, the terms of the legal documents will control. The SPD will only govern if the conflict or inconsistency relates to eligibility, except as described in the "State Insurance Mandates and Dependent Coverage" section in the Participation chapter. From time to time, there may be changes in the benefits and/or procedures under the benefit options contained in this ETTP Plan. In the case of a material change, you will be notified in writing of the change. Notices and announcements will normally be sent directly to you at the address that appears on your employer's records. For this reason, it is important that you notify your employer when you have a change of address. You should also keep announcements and notices with this booklet for your future reference.

The ETTP Plan, as amended and restated, is effective January 1, 2016. As of that date, the amended and restated ETTP Plan entirely supersedes and replaces all prior governing documents. The ETTP Plan has since been amended. The ETTP Plan was established to combine various health and welfare benefits in a single document. For purposes of the annual reporting requirement (on Form 5500) and for compliance with other laws, this ETTP Plan is considered a wrap plan, which means that this single document incorporates several different Benefit Options to comprise one plan for purposes of meeting the reporting and disclosure requirements under the Employee Retirement Income Security Act of 1976.

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WHAT'S INSIDE

This SPD contains important information on many of the benefit programs offered under the East Tennessee Technology Park Health and Welfare Benefit Plan (the "ETTP Plan"). Please read it carefully and maintain in your records.

AN OVERVIEW OF YOUR HEALTH AND WELFARE BENEFITS

The ETTP Plan offers you a variety of benefits and levels of coverage ("Benefit Options") from which you can choose if you meet certain eligibility criteria. All of the Benefit Options available under this ETTP Plan are listed below, in Appendix A and described throughout this SPD, but you are only eligible for the Benefit Options offered by your employer or former employer as a Participating Employer in this ETTP Plan. Eligibility criteria may also vary for each Benefit Option. You should refer to your annual enrollment or new hire information, as applicable, for more information about the available Benefit Options that are offered by your employer for eligible active employees and eligible retirees. You may also reference Appendix A for a listing of benefits provided by your employer under the ETTP Plan.

All Benefit Options available under this ETTP Plan that Participating Employers may choose to offer (Note that your Participating Employer may not have chosen to offer all of the Benefit Options. Please refer to the table in the Participation section for the Benefit Options offered by your Participating Employer as well as any eligibility requirements, including for eligible retirees):

- Medical Coverage
- Dental Coverage
- Vision Coverage
- Long-Term Disability
- Life Insurance (Basic, Supplemental and Dependent)

References to these Benefit Options throughout this SPD apply only to the eligible employees or eligible retirees of the Participating Employers to whom such Benefit Options are available. You should refer to your annual enrollment or new hire information, as applicable, for more information about the available Benefit Options that are offered by your employer for eligible active employees and eligible retirees.

The ETTP Plan does not pay your bills or pay you any cash benefits. Rather, the benefits provided by the ETTP Plan consist only of the payment of some or all of the premiums on insurance contracts. If you incur covered expenses, or become entitled to cash benefits, it is up to the insurance carrier to pay those expenses (or pay the cash benefits, if applicable) to the extent provided in the insurance contract.

We recommend you read the insurance booklets, certificates of coverage, and any other literature prepared by the insurance carrier, which describe the benefits and the procedure for receiving benefits under the insurance coverage or Benefit Options. If you do not have full versions of those documents, they are available upon request to the Plan Administrator. Any document comprising the SPD, including certificates of coverage, is available free of charge.

If you are not sure whether an expense or benefit is covered by insurance, you should ask the insurance carrier.

If you or your employer ceases to pay premiums on an insurance contract for any reason, your coverage under that insurance contract (and under the ETTP Plan for that benefit) will terminate automatically as of the close of the last period for which the premium was paid in full. Unusual circumstances that are not in the normal course of business, as determined by the Plan Administrator in its sole discretion, will warrant a review by the Plan Administrator before coverage is terminated.

Introduction

THIRD PARTY ADMINISTRATORS

For purposes of administrating the various Benefit Options under the ETTP Plan, the Plan Administrator has retained the services of certain independent third party administrators and insurance companies. Generally the third party administrator does not assume liability for benefits payable under this ETTP Plan; some third party administrators, however, may be designated as a "named fiduciary," as that term is defined by Employee Retirement Income Security Act (ERISA), for purposes of processing claims.

MORE INFORMATION

We encourage you to retain this SPD for future reference. If you have questions about your benefits, please contact the Benefits Administrator whose contact information is included in the "General Information" section at the end this SPD.

The role of your employer's benefits department with the ETTP Plan's insurers and third party administrators is to assist you with questions you may have about this ETTP Plan. However, statements made by such representatives do not have a binding effect on the ETTP Plan. If you need to bring or appeal a claim under this ETTP Plan, you should follow the formal claims and appeals procedures described in this SPD.

This SPD is based on legal documents currently in effect (such as plan documents, insurance contracts and summaries, and Coverage Booklets). These documents provide further detail on coverage benefits as well as important exclusions, limitations, and requirements applicable to receive benefits. You may obtain a copy of any of the official legal documents for your coverages by contacting the Plan Administrator at the contact information listed in the "General Information" at the end of this SPD.

RIGHT TO AMEND

UCOR, as the ETTP Plan Sponsor, and the Benefits and Investment Committee (BIC), as the Plan Administrator, reserve the sole discretionary right to modify, amend, suspend, or terminate the ETTP Plan, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by the Amendment Committee, UCOR's Board of Managers, UCOR's President and Project Manager, or its designee.

UCOR's decision to change or terminate the ETTP Plan could result from:

- Changes in federal or state laws governing employee benefits;
- Changes in an insurance contract or policy involving an insurance company;
- Changes in a collective bargaining agreement; or
- Any other reason.

If the ETTP Plan is modified, amended or terminated, you will be notified of the effect of such change to your Plan benefits or coverage. However, the modification, amendment or termination may be effective before you are notified, to the extent permitted by law. Subject to the terms of any collective bargaining agreement or applicable law, no consent of any employee or any other person will be necessary to modify, amend, suspend, or terminate the ETTP Plan described in this SPD.

PARTICIPATION

YOUR ELIGIBILITY AND ENROLLMENT

If you are an eligible active employee or eligible retiree, you may be eligible for some or all benefits as described in the table below. Questions regarding your benefits or this SPD should be addressed to the Benefits Administrator as defined in the General Information section of this SPD.

Independent contractors and leased employees are not eligible to participate in the ETTP Plan.

	BENEFITS FOR ELIGIBLE EMPLOYEES AND ELIGIBLE RETIREES				
	MEDICAL	**DENTAL**	**VISION**	**LIFE**	**LONG-TERM DISABILITY[3]**
UCOR					
SALARIED	*	*	*	Yes	Yes
BARGAINING UNIT	*	*	*	Yes	Yes
FLUOR BWXT					
SALARIED	No	No	No	Yes	No
BARGAINING UNIT	Yes	Yes[1]	Yes	Yes[2]	No
PORTSMOUTH MISSION ALLIANCE					
SALARIED	No	No	No	Yes	No
BARGAINING UNIT	Yes	Yes[1]	Yes	Yes[2]	No
FOUR RIVERS NUCLEAR PARTNERSHIP					
SALARIED	No	No	No	Yes	Yes
BARGAINING UNIT	Yes	Yes	Yes	Yes	Yes
WASTREN ADVANTAGE INC.					
SALARIED	No	No	No	Yes	Yes
BARGAINING UNIT	Yes	Yes	Yes	Yes	Yes
ELIGIBLE PRE-AGE 65 RETIREES	**	Yes	Yes	Full Basic or Reduced Paid-up Life	No
ELIGIBLE POST-AGE-65 RETIREES	**	No	No	Reduced Paid-Up Life	No
*	Benefit offered through UCOR Health and Welfare Benefit Plan				
**	Benefit offered through ETTP Retiree Medical Benefit Plan				
1	Employee or Family Coverage Tier				
2	Employee Basic and Employee Voluntary Life				
3	Basic LTD is company-provided and does not require enrollment. Optional Salaried LTD Buy-up is paid by the employee and enrollment is required				

Participation

Participation in the ETTP Plan does not begin unless you actually enroll, except for certain coverages that are provided automatically to eligible employees of certain Participating Employers. The company-provided benefits are life insurance and basic LTD.

If you are a newly hired employee and you are eligible for benefits under this ETTP Plan, you will receive enrollment information from your employer, including an enrollment notice. The deadline for new hire enrollment in the ETTP Plan is within 31 days following the date of hire (or 31 days following the first date of new eligibility, if later).

Subject to certain exceptions and if you timely enroll for coverage, your coverage will begin on the date set forth in the insurance documents for each Benefit Option. If you have questions about when your coverage begins, you can contact the Benefits Administrator at the contact information listed at the end of this SPD.

Payroll deductions for your share of the coverage costs will begin as soon as administratively feasible based on your eligibility date and pay cycle. Your contribution for a pay cycle will not be pro-rated by how many days of coverage are provided during that pay cycle.

Preexisting Conditions

Benefits under the Long-Term Disability program may be limited if you have a disability due to a preexisting condition. See the "Disability" section of this SPD and the insurance contracts for details.

If you are an eligible employee of a Participating Employer and receive disability income benefits pursuant to the terms of a short-term or long-term disability program maintained by a Participating Employer, you are eligible to participate in some or all of the Benefit Options (as described in the applicable Benefit Options in this SPD) if:

- you were eligible to participate in this ETTP Plan immediately prior to an illness or injury for which you are receiving disability benefits under an employer-sponsored short-term or long-term disability program, or

- you were eligible to participate in the ETTP Plan immediately prior to an illness or injury for which you have timely applied for, and are awaiting approval of, disability benefits under an employer-sponsored short-term or long-term disability program.

YOUR ELIGIBILE DEPENDENTS

Subject to certain limitations, your eligible dependents may also participate in the ETTP Plan. Your eligible dependents generally include your:

- ***Legal Spouse*** where "Spouse" means the individual who is your legal husband or your legal wife in a marriage (whether an opposite-sex or same-sex spouse).

- ***Children*** to age 26, which can include:

  - ✓ Your natural children;

  - ✓ Your stepchildren;

  - ✓ Your legally adopted children (including children placed with you for adoption);

  - ✓ A child age 26 or older who, because of a mental or physical disability, lives with you and depends on you for financial support if the child's disability occurred before the child attained age 26 and was covered under this ETTP Plan prior to attaining age 26 (or another limiting age under applicable state laws).

Participation

- ✓ A child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO)(excluding child life and AD&D coverage);
- ✓ For the medical, dental, and vision Benefit Options, a foster child placed with you through a legally accredited agency or by the courts; and
- ✓ As required under applicable state law for participants who live in Louisiana, your grandchildren who are in your legal custody and have not reached age 26.

Different Dependent Eligibility Criteria for Certain Benefit Options

The Benefit Options may have different dependent eligibility criteria (e.g., Dependent Life Insurance). Although some different dependent eligibility criteria are set forth below, please see the dependent eligibility criteria for each section of this SPD and applicable insurance documents and Coverage Booklets for more information.

For purposes of the Life Insurance Benefit Options, eligible children must be between the age of 4 months and age 19. However, children age 19 to age 23 may be eligible for this Benefit Option if the child is a full-time student at an approved school and not employed on a full-time basis.

State Insurance Mandates and Dependent Coverage

A number of states have laws requiring insurance companies to extend eligibility for coverage to a certain class of dependents that may not be reflected in the eligibility rules above. Those laws, if any, generally will be reflected in the Certificate issued to you by the insurance company. If you believe that an insurance company in your state is required by law to make insurance coverage available for your dependent(s), you should contact the Benefits Administrator using the contact information at the end of this SPD and request such coverage.

Proof of Dependent/Disabled Status

From time to time you may be required to provide documentation as proof of your spouse or dependent's eligibility status, including such items as a marriage certificate, birth certificate, or adoption papers. Failure to provide adequate documentation, upon request, may result in termination of coverage for the affected individual(s) without any coverage extension under COBRA. In addition, coverage of ineligible dependents is in violation of the ETTP Plan's terms. If you are identified as covering ineligible dependents, you may be subject to legal action and discontinued from Plan coverage.

A disabled child that is continuing coverage beyond any limiting age while he or she is disabled will be required to provide proof of a mental or physical disability, including the Social Security Administration Disability Award Notice, to continue coverage.

Qualified Medical Child Support Order ("QMCSO")

The ETTP Plan also provides medical coverage for your child pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO"). A QMCSO is either a National Medical Child Support Notice issued by a state child support agency or an order or a judgment from a state court or administrative body directing your employer to cover a child as your dependent under the ETTP Plan for medical coverage. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid.

If the ETTP Plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the affected child. If you have any questions or you would like to receive, free of charge, a copy of the written procedures for determining whether a QMCSO is valid, please contact the Plan Administrator.

Participation

No Duplication of Coverage

You cannot be enrolled in this ETTP Plan as both a participant and a dependent. Also, no person may be covered as a dependent of more than one participant in the ETTP Plan.

Affordable Care Act ("ACA") Marketplace Enrollment (subject to prevailing law)

You may prospectively revoke your election for medical coverage under the ETTP Plan if you are eligible for and intend to enroll in new health coverage through the Affordable Care Act Marketplace (or "ACA Marketplace") (during its special enrollment period or annual open enrollment period) that is effective beginning no later than the day immediately following the last day of the ETTP Plan medical coverage that is revoked. The ACA Marketplace is a public government sponsored exchange that offers a variety of individual health coverage alternatives for U.S. citizens, some of which could be subsidized by the federal or state government in the form of premium tax credits. This "ACA Marketplace Enrollment" exception is not applicable to the Health Care Flexible Spending Account Program. If you purchase health coverage through the ACA Marketplace instead of electing coverage offered by your employer under this ETTP Plan, you will lose the employer contribution to your premiums for the medical, dental, and vision Benefit Options, if any, that are available to you for health coverage under this ETTP Plan. Note that the ACA Marketplace is different than the alternatives offered to eligible retirees in a private exchange under the ETTP Retiree Medical Benefit Plan.

Medicaid Assistance Under Medicaid and the Children's Health Insurance Program ("CHIP")

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have premium assistance programs that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state that provides assistance, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer's plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

For more information on special enrollment rights, you can contact either of the following entities:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Participation

COST OF COVERAGE

The cost of each Benefit Option will be provided to you each year automatically by your employer during annual enrollment. The provider network for each Benefit Option is described in the separate insurance documents for that Benefit Option and are incorporated by reference into this SPD. A list of providers under any network for a Benefit Option will be furnished automatically to you, without charge, as a separate document.

You may have the opportunity to pay for coverage under certain Benefit Options with pre-tax dollars deducted from your gross pay each pay period if your employer sponsors its own cafeteria plan. You should check with your employer's human resources department for more information. Using pre-tax dollars reduces your taxable income for federal, Social Security and (in most cases) state income tax purposes, making more of your paycheck available for you and your family. Using pre-tax dollars to pay for Plan benefits will not, however, reduce your coverage level for any Plan benefit that is based on your income (e.g., your coverage level of basic life insurance).

You may have to pay for coverage under some Benefit Options on an after-tax basis. This means that you pay for the cost of coverage with your already-taxed dollars (your take-home pay or your net income). Your after-tax contributions are also deducted from your paycheck each pay period. IRS rules determine how each benefit you receive is taxed.

If your employer pays for your life insurance benefits, your coverage is tax-free if your coverage does not exceed $50,000. If your employer-provided coverage exceeds $50,000, you will have imputed income and are taxed on the cost of the coverage over $50,000, which is added to your Form W-2 for tax purposes.

Please note: Using pre-tax dollars can affect any Social Security benefits you may eventually receive. This is because you do not pay Social Security (FICA) taxes on pre-tax dollars. If you earn less than the Social Security "taxable wage base" after making contributions to the ETTP Plan, your pre-tax contributions to the ETTP Plan will lower the portion of your wages that is subject to Social Security taxes. As a result, your Social Security taxes will be lower, which may, in turn, cause your Social Security benefits to be slightly lower when you retire or if you become disabled. The amount of benefit reduction will depend on the amount of your pre-tax contributions and how long you participate in the ETTP Plan before you retire. If you have any concerns, or if you need additional information, contact your local Social Security Administration office or consult your financial advisor about the effects of your participation in the ETTP Plan.

Please note: Coverage under the ETTP Plan is subject to your payment of any required contribution unless, in the case of a child who is eligible for coverage pursuant to a QMCSO, payment of the required contribution is made by a state agency.

Remember that income tax laws change frequently, and these changes affect different individuals in different ways. Therefore, your employer cannot assure you that it will be to your advantage to participate in the ETTP Plan on a pre-tax or after-tax basis.

ENROLLMENT

Enrollment Opportunities

The ETTP Plan has three types of enrollment opportunities:

- Initial enrollment—You must enroll within 31 days of eligible employment;
- During annual enrollment—You must enroll during the enrollment period designated in the enrollment materials; and

Participation

- Within 31 days after you have a change in status or experience another event that allows you to make a mid-year election change (60 days may be allowed for very limited types of events related to state Medicaid assistance).

Enrolling

Upon becoming initially eligible and before each annual enrollment, you will receive enrollment information that will let you know how and when to enroll for coverage. To obtain medical coverage, you will be required to provide a valid Social Security number for yourself and each dependent that you wish to cover, as well as the date of birth for each covered person. A Social Security number will not be required for a child until the child's first birthday.

The elections you make will stay in effect for the entire Plan year (January 1 – December 31) unless you change them upon an event permitting a mid-year change in elections or during a subsequent annual enrollment period. See the "Changing Coverage During the Year" section for information on mid-year enrollment and changes.

Annual Enrollment

Each fall, your employer has an enrollment period for benefits for the following Plan year (January 1 – December 31). You must review your annual enrollment materials to know whether you need to take action or not. Every year can be different. Most annual enrollments are "active," requiring you to take action and make elections in order to have coverage. Some annual enrollments are "passive," meaning some or all of your previous benefit elections will remain in effect and you will not be required to make elections in order to have coverage.

During annual enrollment, you may elect coverage under any of the applicable Benefit Options. The elections you make during annual enrollment generally take effect on the following January 1, the start of the new Plan year. See the "Coverage During Absences" section for special rules regarding enrollment after an unpaid leave of absence.

During annual enrollment, you may have the opportunity to:

- Switch from one medical option or dental option to another (if several options are offered in your location), add or drop dependents, or decline or add medical (including prescription drug), dental or vision coverage for the next calendar year.

- With respect to income protection—disability and life coverage—you may be able to enroll for coverage (if not automatically provided), or increase or decrease the level of life insurance coverage for you or your dependents, subject to certain conditions. Certain other restrictions may apply. Please see the "Disability" and "Life" sections of this SPD for further details.

If you are on a leave of absence at the time of annual enrollment, your elections may be affected. Please contact the Benefits Administrator for further details.

Notwithstanding the above, if your premiums for benefits under this ETTP Plan have not been paid in full as of the first day of the annual enrollment period (occurring in the fall), you may not be eligible to participant in the plan for the next plan year beginning on January 1st.

Special Circumstances: Re-employment

If you leave your employer and subsequently return to work for your employer as an eligible employee, the following rules will apply:

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- If you are rehired within 30 days and within the same Plan year (January 1 – December 31), your prior elections will be reinstated if you are rehired into a benefits eligible position;

- If you are rehired more than 30 days after you terminate, you will be eligible to make new elections; or

- If you are rehired within 30 days but in the ETTP Plan year following the ETTP Plan year in which you terminated employment, you will need to make new coverage elections.

Changing Coverage During the Year

As a general rule, you will be allowed to make coverage changes only if an event results in you, your spouse, or your dependents gaining or losing coverage eligibility under an employer-sponsored plan. Your change in coverage must be consistent with the event (sometimes called a "change-in-status" event or "life" event). For example, if you get married, you can change your level of medical coverage from employee only to employee plus dependent.

Each Participating Employer (or its designee), in its sole discretion, shall determine whether an event permits an election change and, if so, whether the election change is consistent with the event, in accordance with rules established by the IRS.

Election Period for Changing Coverages and Effective Date of Coverage

If you experience an event permitting you to change any of your health and welfare coverages, you must notify your employer's benefits department and make your election changes within 31 days after the event (60 days for a loss of eligibility for Medicaid or State Child Health Plan or a gain of eligibility for premium assistance under Medicaid or State Child Health Plan), or any longer period specified below. If timely made, coverage changes made due to a mid-year event are generally effective on the first of the month following a timely election change. Two exceptions are:

- For enrollment of a child pursuant to a QMCSO, coverage will be effective as soon as administratively possible after the Plan Administrator determines the QMCSO is valid;

- For HIPAA special enrollment of a child as a result of birth, adoption or placement for adoption, coverage will be effective as of birth or the date on which you acquired the child (except for the life insurance Benefit Option which has a minimum age requirement of 4 months).

If you do not make a timely election, you will not be able to make a mid-year election and will have to wait until annual enrollment (or a subsequent election change event) to make any election changes.

The ETTP Plan Administrator reserves the right to require, at any time, appropriate documentation of your change in status or other event.

Important Notes Regarding Mid-Year Election Changes

- For changes in status resulting in either you or a dependent becoming ineligible, coverage automatically ends as of the event resulting in your or your dependent's ineligibility (except that medical, dental, and vision coverage extends through the end of the month for dependents losing eligibility due to reaching age 26). The mid-year election change will stop the premium deduction that relates to the cost of coverage.

- If you become divorced or legally separated or a dependent child is no longer eligible for coverage, your spouse or child will lose eligibility for medical coverage under the ETTP Plan on the day the event occurs (except that coverage extends through the end of the month for dependents losing eligibility due to reaching

age 26). Please see "Medical Coverage Continuation Rights (COBRA)" later in this section for more information on COBRA for such individuals.

Unpaid Absences

The beginning of an extended unpaid absence could be a change in status permitting election changes. To assist you in determining whether your extended absence is paid or unpaid and triggers your right to make an election change, you should contact your employer's benefits department.

Coverage During Unpaid Absences

In the event you qualify for an unpaid leave of absence under your employer's leave of absence policy (like a Family Medical Leave Act (FMLA) leave or personal leave), your coverages may be impacted during your leave of absence. You should check with your employer's human resources department for information on how to keep coverage during an unpaid leave of absence.

Reinstatement of Benefits

If your coverage ceases (e.g., for non-payment of required contributions) during an approved leave of absence ("LOA") (including a medical, family, or military LOA), you will be permitted to elect to again participate in the ETTP Plan upon your return from the LOA as permitted under the applicable Benefit Options. Please refer to the Certificates of Coverage for each benefit Option for more information or contact your employer's human resources department.

Furlough Periods

A "furlough period" means a period of furlough implemented by your employer due to a failure by Congress to pass legislation to fund the Federal government and resulting in a shortage of operating funds to the employer. If your coverage under any Benefit Option is discontinued during a furlough period due to late or nonpayment of premiums (whether by you, your employer, or both) or other reasons relating to a furlough period, your coverage will end on the last day of such insurance coverage. At the end of the furlough period, you will be allowed to have your benefits reinstated at the same level of benefits and coverage at the beginning of the furlough period. If coverage is continued through the furlough period, you will be responsible for your portion of any outstanding premium payments.

Allowable Mid-Year Change Events

Election changes may be allowed if you or your dependent experiences certain events. The election change must be on account of and correspond with a change-in-status event, as determined by the Plan Administrator (or its designee), and it must affect eligibility for coverage. Generally, the change-in-status events are:

- Change in Legal Marital Status (such as a marriage, death of a spouse, divorce, legal separation, or annulment);

- Change in the Number of Dependents (such as a birth of a child, the adoption or placement for adoption of a dependent, or death of a dependent);

- Change in Working Status that could affect benefit eligibility (such as termination or commencement of employment, strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly or union to non-union or part-time to full-time, incurring a reduction or increase in hours of employment, or similar change which makes the individual become eligible or loss eligibility for a particular Benefit Option);

- Dependent Eligibility Requirement (such as attaining a specific age); or
- Change in Residence.

This is only a summary of some of the permitted change-in-status events and is not all inclusive. Further, the Plan Administrator has discretion to determine that a change in coverage is allowed mid-year due to a certain event you experience and based on the terms of the ETTP Plan.

WHEN COVERAGE ENDS

Your Coverages End

Your coverages end upon the first of the following to occur:

- Your employment with your employer ends (e.g., you retire, quit or are terminated);
- You are no longer eligible to participate;
- You fail to timely pay your required contributions;
- You elect to terminate coverage;
- You knowingly make, or cause or permit to be made, false statements in order for you or another person to obtain Plan services or payment to which you or the other person are not entitled;
- The ETTP Plan Sponsor, UCOR, terminates the Benefit Option in whole or in part;
- Your employer is no longer a Participating Employer in this ETTP Plan (unless you are an eligible retiree);
- Coverage is terminated for the eligible class to which you belong;
- Your employer's contract to perform services as a first or second tier subcontract ends (unless you are an eligible retiree); or
- Your employer's contract to perform services as a new prime contractor or a new subcontractor ends (unless you are an eligible retiree).

Termination of your medical, vision, and dental coverages will be effective on the last day of the month in which the triggering event occurs. All other coverages terminate immediately upon your termination of employment or other triggering event.

Your Dependent's Coverages End

Your dependent's coverage ends upon the first of the following to occur:

- You fail to submit requested documentation of dependent status in connection with a dependent coverage verification;
- When your coverage ends;
- Your dependent no longer meets the eligibility requirements; or
- You cease to be a participant in this ETTP Plan.

Participation

Termination of medical, vision, and dental coverage for your child due to your child attaining age 26 is effective on the last day of the month that includes the child's 26th birthday.

ADMINISTRATION

Administration

COORDINATION OF BENEFITS

Your medical coverage is fully insured by an insurance carrier. The Coverage Booklets made available by the insurance carrier (the "Coverage Booklets") provide more detail with regard to coordination of benefits, whether with other plans or with Medicare. See the General information section for how to access these Coverage Booklets.

SUBROGATION AND REIMBURSEMENT

Your medical coverage is fully insured by an insurance carrier. The Coverage Booklets made available by the insurance carrier (the "Coverage Booklets") provide more detail with regard to the ETTP Plan's subrogation rights. See the General information section for how to access these Coverage Booklets.

If you receive or become eligible to receive any medical, dental, or disability benefit arising from an accident, injury, or illness for which you can assert any claims or rights to recovery against a third-party, then any payments under this ETTP Plan are made on the condition that you will reimburse this ETTP Plan for any amounts you receive from a third-party as a result of an accident, injury, or illness, you will serve as a constructive trustee over the funds that constitute that payment, and a failure to hold such funds in trust shall be deemed a breach of your fiduciary duty to the ETTP Plan. The "make whole doctrine" arising under Federal common law and under State law does not apply to this ETTP Plan's reimbursement or subrogation rights. The ETTP Plan Administrator, in its sole discretion, may determine to reduce the reimbursement to the ETTP Plan from you by attorneys' fees and other expenses paid by you during your recovery against a third-party.

LIFE INSURANCE AFTER YOU LEAVE

This section provides a brief description of the conversion, portability, and continuation rights you may have for certain insured benefits. For more information about your rights, as well as terms, limitations and restrictions, please refer to the insurance documents, including your certificate of coverage, for the specific insured Benefit Option. You may also contact the insurance company to request these documents and obtain more information about possible coverage after you leave your current employer.

***Conversion Rights*.** These rights apply to employee basic and supplemental life insurance; dependent life insurance. You or your dependent may convert to an individual policy if your employment with your employer ends, you become ineligible for coverage, or your employer ceases participating in the ETTP Plan so that group life insurance terminates (limited rights apply in this circumstance). To timely convert to an individual policy, you or your dependent must apply for conversion with the appropriate insurance company listed in the "General Information" section at the end of this SPD and pay the first premium within 31 days after your coverage ends.

Portability Rights. These rights apply to salaried employee supplemental life insurance. If you have supplemental life insurance coverage (including dependent coverage) and your coverage ends, you may elect to continue group coverage for yourself and/or your dependent under a portability plan by paying the premiums due directly to the insurance company instead of converting the coverage to an individual policy. You must apply within 31 days after your coverage ends and, unlike your right to convert, Evidence of Insurability may be required. Generally, your portability rights are in lieu of your conversion rights.

Administration

HEALTH CARE COVERAGE CONTINUATION RIGHTS (COBRA)

A federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) allows you and your covered dependent (including your covered spouse or child) to continue your medical, dental and vision care on an after-tax basis in certain situation when existing coverage would otherwise end. Upon a qualifying event (described below), you and your covered dependents may be able to continue these coverages. If otherwise eligible, you and each of your covered dependents have an independent right to elect COBRA continuation coverage.

Electing COBRA

If you and/or your dependents choose continuation coverage through COBRA, you and your covered dependents are offered coverage on the same basis as other participants, except you or your affected dependents pay the entire cost plus a 2% administrative fee (or a 50% administrative fee in the case of an 11-month extension due to disability). COBRA coverage is intended to extend the coverage that is in effect for you and your covered dependents on the day before your qualifying event. COBRA coverage does not create new classes of covered individuals. To be eligible for continuation of coverage, your employer-provided health care coverage must be in effect on the date before the qualifying event. For your dependents to be eligible for continuation of coverage, they must also be enrolled for coverage on the day before the qualifying event.

As noted above, if you elect COBRA coverage, you will receive the same coverage that was in effect on the day before the qualifying event. However, you may change your coverage choices during the annual enrollment period that falls during your COBRA continuation coverage period. If your covered dependents elect COBRA, these same rights apply.

COBRA coverage takes effect on the date coverage is lost on account of the qualifying event if a timely election is made. While your employer will notify its COBRA Administrator of your qualifying event in the case of your termination from employment (or service, as applicable), reduction in hours or death, it is your (or your covered dependent's) responsibility to notify the COBRA administrator of any other qualifying event (e.g., divorce, child reaching age 26). In addition, you may add a newborn or an adopted child during the COBRA continuation period in accordance with the HIPAA "special enrollment" rules outlined earlier. Your newborn or adopted child's coverage begins immediately.

Reporting a Qualifying Event

You or your affected covered dependent must notify the Benefits Administrator either in writing or orally within 60 days after the date on which coverage is lost on account of any of the following qualifying events:

- You divorce or become legally separated;
- Your child no longer meets the definition of a dependent (e.g., due to age limit); or
- You (or your covered dependent) are determined to have been disabled under the Social Security Act when coverage ended or at any time during the first 60 days of receiving COBRA continuation coverage.

When you or your affected covered dependent contact the Benefits Administrator, be sure to inform them of the specific event, the date of the event and who is affected. Please note that you may be required to provide documentation concerning the qualifying event.

The COBRA Administrator sends you and/or your affected covered dependent a notice and election form, including the cost of coverage, within 14 days of receiving this notification.

Your employer informs the COBRA Administrator within 30 days of the loss of your coverage on account of any of the following qualifying events:

- Reduction in hours that makes you ineligible for coverage;
- You are laid off;

- You do not return from an FMLA leave of absence;
- Your termination of employment (or service, as applicable) for any reason other than gross misconduct;
- You become entitled to Medicare; or
- Your death.

The COBRA Administrator sends you and/or your affected covered dependents a notice and election form, including the cost of coverage, within 44 days after one of these qualifying events occur.

Snapshot of COBRA Coverage

Below is a snapshot of who is eligible for COBRA continuation coverage, under what circumstances, and how long COBRA continuation coverage continues for health care coverage. If one of the events listed in the chart occurs, you and your enrolled dependents may apply for COBRA coverage.

Qualifying Event	Who Is Eligible for COBRA	Maximum COBRA Period*
Termination of your employment (or service, as applicable) for any reason except gross misconduct	You and your enrolled dependents	18 months
Reduction in hours of employment (including a military leave of absence)**	You and your enrolled dependents	18 months
You become laid off	You and your enrolled dependents	18 months
You do not return from an FMLA leave of absence	You and your enrolled dependents	18 months
You or your covered dependent become disabled	You and your enrolled dependents	18 months up to 29 months***
Your death	Your enrolled dependents	36 months
Divorce or legal separation (unless a QMCSO provides otherwise)	Your enrolled dependents	36 months
Your child no longer meets the definition of dependent under the ETTP Plan	Your covered dependent	36 months

**The maximum COBRA period is measured from the date you lose coverage on account of the qualifying event. If your qualifying event is termination of employment or reduction in hours of employment and you became entitled to Medicare less than 18 months before the date coverage ended, the maximum COBRA period for your enrolled dependents lasts until 36 months after the date you became entitled to Medicare. If eligible for COBRA under the Health Care FSAs, the maximum COBRA period is through the end of the calendar year in which the qualifying event occurs. See "Health Care Flexible Spending Account" below for details.*

***Note that in the event you become entitled to COBRA coverage due to a loss of coverage triggered by a military leave of absence covered by the USERRA, you will receive continued coverage at the same cost paid by active employees for the first 30 days of your military leave. Also, your continuation coverage period is 24 months, not 18 months.*

****See "COBRA Coverage for Disabilities" below for details.*

Deciding Whether or Not to Continue Coverage

You have 60 days from the day coverage would otherwise end (or from the day the notice is sent to you, if later) to choose continuation coverage.

In order to continue your health care coverage, you and/or your covered dependents must pay the full cost of coverage, plus a 2% fee for administrative costs (or, in the case of an 11-month extension due to disability, up to a 50% administrative fee as determined by the COBRA Administrator).

Administration

Your first payment (due within 45 days of your election) must include your COBRA contribution for the entire period from the date coverage ended through the month of the payment. Subsequent contributions are due on the first of the month, whether or not you receive a bill. If the COBRA Administrator does not receive your monthly contribution within 30 days of the first of the month, coverage is canceled as of the last day of the month in which you paid a contribution. If you do not choose to continue coverage, you should make the appropriate election on the election form and return it to the COBRA Administrator. In that case, your health care coverage ends on the day on which the qualifying event occurred.

Ending Continuation Coverage

Continuation coverage ends when any of the following events occurs:

- You (or a covered dependent) reach the end of the applicable maximum COBRA period for coverage;
- You (or a covered dependent) do not pay a monthly contribution within 30 days of its due date;
- Upon your or your covered dependent's written request to cancel coverage;
- You (or a covered dependent) become entitled to Medicare after the COBRA event;
- You (or a covered dependent) subsequently become covered under another group medical or dental plan that does not contain a preexisting condition rule; or
- Your employer ceases to provide any group health plan coverage.

Please inform the Benefits Administrator of any changes in address or in personal circumstances so that you and your covered dependents can receive the necessary information concerning your rights to continuation of coverage. However, if you are already receiving COBRA, please contact the COBRA Administrator to update any changes in address or in personal circumstances.

COBRA Coverage for Disabilities

COBRA coverage can be extended from 18 months up to 29 months if you (or another qualified beneficiary) are totally disabled when you (or the other qualified beneficiary) become eligible for COBRA coverage or become disabled during the first 60 days of COBRA coverage. Monthly contributions for continuation coverage may increase to 150% (from 102%) of the monthly amount for each of the 11 additional months of continuation coverage (any covered dependents can also continue their COBRA coverage during this extension period).

To be eligible for this extension, the individual must:

- Receive a determination of disability from the Social Security Administration (SSA) that the individual was disabled on the date coverage ended, or became disabled during the first 60 days of COBRA coverage, and
- Notify the Benefits Administrator prior to expiration of the original 18 month coverage period and within 60 days after the later of:
  - ✓ The date of the SSA's determination of disability; or
  - ✓ The date of the qualifying event.

If the SSA determines that the individual is no longer totally disabled, continuation of coverage will cease. The individual must notify the COBRA Administrator listed at the end of this SPD within 30 days of any such finding. Coverage will terminate on the earlier of the first day of the month that is at least 30 days after the SSA's findings or at the end of the 29-month period.

Administration

Administration of COBRA

If you have any questions about COBRA or if you are required to notify your employer of any event to trigger COBRA obligations, please contact the Benefits Administrator. Upon any required notification by you, the Benefits Administrator will contact the COBRA Administrator to send you any necessary paperwork. The ETTP Plan Administrator has engaged a COBRA Administrator to assist with the sending and receiving of COBRA information, including the collection of COBRA premiums if elected by participants.

State Continuation Coverage

Certain states, such as California, provide for continuation coverage extending beyond the date your federal COBRA coverage ends. You should contact your insurer at the address listed in the Coverage Booklet provided by the insurer for more information.

Other Coverage Options Besides COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Displaced Worker Medical Benefit Program (through the Department of Energy), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

CLAIMS AND APPEALS

CLAIMS AND APPEALS

This section reviews what you need to do to file claims for the different Benefit Options in the ETTP Plan. If you have any questions about filing claims, please call the appropriate administrator as listed in the General Information section at the end of this SPD. You may also contact the insurance company for more information about the claim procedures for a specific Benefit Option. If your initial claim for benefits is denied, you should follow the claims and appeals procedures described in the applicable insurance documents for that Benefit Option. If there is no such procedure under the applicable insurance documents that governs the disposition of a claim or dispute, or such procedure violates applicable law, then the claims procedure described in these procedures shall govern.

The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with governing Plan documents and that, where appropriate, the ETTP Plan provisions have been applied consistently with respect to similarly situated participants. You and your Plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Types of Claims

There are two general types of claims: a claim regarding eligibility or enrollment, and a claim for benefits.

Claim Regarding Eligibility or Enrollment. This is a claim involving eligibility under a Benefit Option or enrollment in a Benefit Option. The ETTP Plan Administrator, generally determines these types of claims. If you are denied disability or life coverage because you did not satisfy an insurance requirement for coverage (e.g., Evidence of Insurability), any inquiries or claims should be directed to the Claims Administrator (who is the insurance company for the coverage). These are referred to as "Eligibility Claims" below.

Claim for Benefits. A claim for benefits is the more common type of claim and is a request that benefits be paid under the applicable program. These are referred to as "Benefit Claims" below.

Filing Initial Benefit Claims

You may or may not need to file an initial claim to receive benefits. For a medical coverage with a network provider, if you receive in-network services, you do not need to file a claim—the provider should do that for you. However, if you receive non-network medical services you will be responsible for filing your own claims.

For more information regarding the claims filing process, see the insurance documents and certificate for your Benefit Option.

Timely Filing of All Claims

You should make every reasonable effort to file claims promptly after you incur services. In most cases you have up to 12 months from the date of service to file your claim. Claims filed or received after 12 months are not generally eligible for payment.

IF A CLAIM IS DENIED

If your claim for benefits under the ETTP Plan is denied, in whole or in part, you may have it reviewed in accordance with the following claims review procedures. The procedures will vary depending on the type of benefit claim it is. It is important to follow the procedures explained below. If you do not follow these procedures, you may be giving up important legal rights, such as the ability to file a claim in a court of law. If the procedures below are exhausted and you are not satisfied with the decision that has been made, you have the right to file a lawsuit.

These review and appeal procedures are governed by federal regulations. If anything described below is contrary to what federal regulations and other federal guidance would require, the federal information will

control. The procedures are different depending on the type of benefit that is involved, which is explained below and in the applicable insurance documents for the Benefit Option.

Denial of Claims by the Insurance Company who is a Claims Administrator

If your claim for an insured or third-party benefit is denied under the ETTP Plan, you should refer to the applicable insurance policy or insurance Certificate of Coverage provided by the carrier, or contact the insurance carrier (see the General information section) for more information on the applicable claims procedures for the insurance company. The claim or dispute shall first be disposed of in accordance with the insurance documents governing each Benefit Option, including all time limitations thereunder. The insurance company providing the benefit under a Benefit Option is the "named fiduciary" for purposes of such Benefit Option. If there is no such procedure under the applicable insurance documents that governs the disposition of a claim or dispute, or such procedure violates applicable law, then the claims procedure described in these procedures shall govern.

Claims Process

Filing an Eligibility Claim

If you believe that you or your dependent is eligible or entitled to enroll under the ETTP Plan or a specific Benefit Option, you may file a claim in writing with the Plan Administrator**.** You must submit claims for all benefits to the Plan Administrator (or its designee) within one year from the date service was provided. If you do not submit claims for benefits within one year from the date service was provided, you will be ineligible to receive reimbursement from the applicable Benefit Option for any expenses incurred, and you will be responsible for payment of all expenses incurred. You will be entitled to a review of your claim file and to present evidence and testimony as part of the claim and appeal process.

Initial Benefit Claims

Benefit Claims that are Not Medical or Disability Claims: When a claim is received that is not a medical or disability claim, the Plan Administrator or Claims Administrator must notify you of its benefit determination within 90 days of the receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved.

Benefit Claims for Disability: When a benefit claim is received that is a disability claim, you will be notified of the benefit determination within a reasonable period of time, but no later than 45 days after your claim is received, unless an extension of up to 30 days is necessary due to matters beyond the control of the ETTP Plan and the Plan Administrator determines and notifies you (or your authorized representative) that such an extension is necessary before the expiration of the initial 45-day period. If, prior to the end of the first 30-day extension period, the Plan Administrator determines that, due to matters beyond the control of the ETTP Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that you (or your authorized representative) is notified prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date as of which the ETTP Plan expects to render a decision. The notice of the extension shall specifically explain the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. You (or your authorized representative) will be afforded at least 45 days within which to provide the specified information.

Benefit Claims for Medical: When a medical benefit claim is received that is a Pre-Service claim (as defined below) that are not Urgent Care claims (as defined below), an initial decision will be made within 15 days of the receipt of the claim. An extension of 15 days will be allowed for processing the claim if special circumstances are involved. If the extension is necessary because you did not submit the information necessary to decide the claim, the notice will describe the required information, you will be given at least 45 days from the receipt of the notice to provide information, and the period of time for deciding your claim will be tolled. Pre-Service claims for Urgent Care will be treated as Urgent Care claims. In the case of a failure to follow the Claim Procedures for filing a Pre-Service Claim, you (or your authorized representative) will be notified of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible but no later than 5 days following the failure. This notification may be oral, unless you (or your authorized representative) request written notification.

When a medical benefit claim is received that is an Urgent Care claim (including Pre-Service claims for Urgent Claim), an initial decision will be made as soon as possible, but no later than 72 hours after your claim is filed. If insufficient information is received, you will be notified as soon as possible, but not later than 24 hours after receipt, of the specific information necessary for the Plan Administrator or its designee to make a decision on your claim. You must provide the requested information within a reasonable time, but no less than 48 hours after notification. You will be provided a determination within 48 hours after the earlier of receipt of the requested information or the end of the period within which you were requested to provide such additional information. In the case of a failure to follow the Claim Procedures for filing an Urgent Care claim, you (or your authorized representative) will be notified of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible but no later than 24 hours following the failure. This notification may be oral, unless you (or your authorized representative) request written notification.

When a medical benefit claim is received that is a Post-Service claim, an initial determination will be made on your claim within 30 days of the receipt of the claim, unless an extension of up to 15 days is necessary due to matters beyond the control of the ETTP Plan. The initial time period may be extended for up to 30 additional days if special circumstances are involved. If the extension is necessary because you did not submit the information necessary to decide the claim, the notice will describe the required information, you will be given at least 45 days from the receipt of the notice to provide information, and the period of time for deciding your claim will be tolled.

When a medical benefit claim is received that is a Concurrent Care claim, it will be treated as a Pre-Service claim described above. If you request to extend the course of treatment beyond the time period or number of treatments and such claim involves Urgent Care, your claim shall be decided as soon as possible, taking into account the medical exigencies. You will be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the ETTP Plan, provided that any such claim is made to the ETTP Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. The appeal of such determination shall be governed as an Urgent Care claim, a Pre-Service claim, or a Post-Service claims, as applicable.

Types of medical benefit claims:

- A “Pre-Service” claim is any claim for a benefit under a group health plan with respect to which the applicable Benefit Option requires you to obtain approval in advance of receiving the medical care.

- An “Urgent Care” claim is any claim for medical care under a group health plan with respect to which the applicable time periods for the Plan Administrator (or its designee) to make a non-urgent service claim determination could either seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without urgent care or treatment. The ETTP Plan Administrator (or its designee) will defer to the attending provider as to whether a claim is an Urgent Care claim.

- A “Post-Service” claim is any claim for a benefit for medical care previously rendered to you.

- A “Concurrent Care” claim is a claim for which the Plan Administrator (or its designee) approves ongoing treatment to be provided over a period of time.

Extensions: You will be given notice of any such extension within the time periods described above. The notice will state the special circumstances involved and the date a decision is expected. If an extension is necessary because of your failure to submit information necessary to make a decision, the period for making the decision will be tolled from the date on which the notice of extension is sent until the date you respond to the request for additional information. If the information requested is not provided with the extension period, your claim will be decided without the necessary information.

Determination of Initial Claim (for both Eligibility Claims and Benefit Claims)

The ETTP Plan Administrator or the Claims Administrator (or its designee) will send you a written notice of how the claim was decided, such as an adverse determination. For purposes of the claim and appeal processes, an “adverse determination” includes a denial, reduction, termination of, failure to provide or make payment (in

whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on a determination of your eligibility to participate in the ETTP Plan or any Benefit Option, a determination that a benefit is not a covered benefit, the imposition of a limitation on otherwise covered benefits (such as a network exclusion), or a determination that a benefit is experimental, investigational, or not medically-necessary or appropriate. An "adverse determination" also includes rescission of the coverage, which is a cancellation or discontinuance of coverage that has a retroactive effect, but does not include a rescission if the cancellation or discontinuance of coverage has only prospective effect or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

An adverse determination for denial of a claim will include:

- The reason(s) for the denial;
- References to the specific plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the plan's appeal procedures and the time limits applicable to the appeal process;
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on appeal;
- In the case of a disability benefit claim or medical benefit claim, you will be notified of or given a statement of any internal rule, guideline, protocol, or other similar criteria that was relied upon in making the adverse determination and that a copy of such criteria will be provided free of charge upon request;
- In the case of a disability benefit claim or medical benefit claim that was based on a medical necessity or experimental treatment or similar exclusion or limit, you will be given either an explanation of the scientific or clinical judgment for the determination, applying the terms of the ETTP Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- In the case of a medical benefit claim, information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code, and the meaning of such codes);
- An explanation of how to request diagnosis and treatment codes (and their corresponding meanings);
- In the case of a medical benefit claim, available external review processes and the time limits;
- In the case of a medical benefit claim, the contact information for any applicable consumer assistance office established under Section 2793 of the Public Health Service Act to assist you; and
- In the case of a medical benefit claim that is an Urgent Care claim, a description of the expedited review process. Further, in the case of a medical benefit claim that is an Urgent Care claim, the information may be provided to you orally within the appropriate time frame followed by a written or electronic notification within 3 days after the oral notification.

You may request and receive, free of charge, reasonable access to and copies of relevant documents, records, and other information in the ETTP Plan's possession. Relevant documents, records, and other information are those that were relied on in making the benefit determination, were submitted/considered/generated in the course of making the benefit determination, demonstrate compliance with the ETTP Plan's or Benefit Option's administrative processes or safeguards, or in the case of a group health plan claim, constitute a statement of the ETTP Plan's or Benefit Option's policy or guideline regarding the benefits for your diagnosis, whether or not relied upon.

Appealing an Eligibility Claim or Benefit Claim Denial

Appeals that are Not Medical or Disability Claim Denial Appeals: If you (or your duly authorized representative) believe that a denial is incorrect, you may request a full review by the Plan Administrator (or its designee) in writing within 60 days after your receipt of denial of your claim. In connection with your appeal, you or your representative may submit written comments, documents, records and other information relating to the claim. The ETTP Plan Administrator decision on appeal usually will be made within 60 days after receiving your appeal, unless special circumstances require an extension of an additional 60 days. If the period is extended, the Plan Administrator will notify you in writing of the extension within 60 days of receiving your appeal.

Appeals that are Disability Claim Denial Appeals: If you (or your duly authorized representative) believe that a denial is incorrect, you may request a full review by the Plan Administrator (or its designee) in writing within 180 days after your receipt of denial of your claim. In connection with your appeal, you or your representative may submit written comments, documents, records and other information relating to the claim. The review given to your appeal will not afford deference to the initial adverse determination and will be conducted by an appropriate fiduciary who is not the same individual who made the initial adverse determination that is the subject of the appeal, nor the subordinate of that individual. If your appeals involves an adverse determination that is based in whole or in part on a medical judgment, including determinations of whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved or in medical judgment. This professional will be an individual who was not consulted in connection with the initial adverse determination that is the subject of your appeal nor a subordinate of that individual. The ETTP Plan will provide for the identification of medical or vocational experts whose advice was obtained on behalf of the ETTP Plan in connection with the initial adverse determination, without regard to whether the advice was relied upon in making the determination.

Appeals that are Medical Claim Denial Appeals: If you (or your duly authorized representative) believe that a denial is incorrect, you may request a full review by the Plan Administrator (or its designee) in writing within 180 days after your receipt of denial of your claim. In connection with your appeal, you or your representative may submit written comments, documents, records and other information relating to the claim. The review given to your appeal will not afford deference to the initial adverse determination and will be conducted by an appropriate fiduciary who is not the same individual who made the initial adverse determination that is the subject of the appeal, nor the subordinate of that individual. If your appeals involves an adverse determination that is based in whole or in part on a medical judgment, including determinations of whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved or in medical judgment. This professional will be an individual who was not consulted in connection with the initial adverse determination that is the subject of your appeal nor a subordinate of that individual. The ETTP Plan will provide for the identification of medical or vocational experts whose advice was obtained on behalf of the ETTP Plan in connection with the initial adverse determination, without regard to whether the advice was relied upon in making the determination. You will be entitled to continue coverage pending the outcome of your appeal to the extent mandated by the ACA, which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. Before issuing a final determination based on a new or additional rationale, you shall be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the decision is required to be provided, as described below, to give you a reasonable opportunity to respond prior to that date.

- Decisions on appeals of Pre-Service claims must be made within 30 calendar days following receipt of the appeal of the adverse determination.

- Decisions on appeals of Urgent Care claims must be made within 72 hours following receipt of the appeal of the adverse determination. If your appeal relates to a medical claim involving Urgent Care, you will have the opportunity to expedite your appeal and the review procedure. In the case of Urgent Care, your appeal may be submitted orally or in writing, and necessary information, including the decision that is made with respect to the appeal, may be given by telephone, facsimile, or other similar expeditious method.

- Decisions on appeals of Post-Service claims must be made within 60 calendar days following receipt of your appeal of the adverse determination.

- Decisions on appeals of Concurrent Care claims are treated as Pre-Service claims, Urgent Care claims, or Post-Service claims, depending on the facts of the appeal and claim. If your appeal relates to a medical claim in which Concurrent Care has been reduced or terminated, you will not necessarily be given 180 days to submit an appeal depending on the facts of the appeal and claim and whether it is treated as a Pre-Service claim, Urgent Care claim, or Post-Service claim. Rather, based on the particular circumstances, you will be given a reasonable period of time to appeal before the benefit is reduced or terminated.

Extensions: You will be given notice of any such extension within the time periods described above. The notice will state the special circumstances involved and the date a decision is expected. If an extension is necessary because of your failure to submit information necessary to make a decision, the period for making the decision will be tolled from the date on which the notice of extension is sent until the date you respond to the request for additional information. If the information requested is not provided with the extension period, your claim will be decided without the necessary information.

Appeals Decision

The ETTP Plan Administrator will furnish you with a written decision providing the final determination of the claim. The ETTP Plan Administrator's review will take into account all comments, documents, records and other information related to the claim, regardless of whether such items were considered in the initial claim decision. The ETTP Plan Administrator's decision on review will be final and binding on you, your dependents and any other interested party. Your appeal notice will include:

- The specific reason or reasons for the appeal decision;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that you have the right to request access to and copies of all relevant documents free of charge;
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA following an adverse determination on appeal;
- A description of the ETTP Plan's appeal procedures and the time limits applicable to the appeal process;
- In the case of a disability benefit claim or medical benefit claim, you will be notified of or given a statement of any internal rule, guideline, protocol, or other similar criteria that was relied upon in making the adverse determination and that a copy of such criteria will be provided free of charge upon request;
- In the case of a disability benefit claim or medical benefit claim that was based on a medical necessity or experimental treatment or similar exclusion or limit, you will be given either an explanation of the scientific or clinical judgment for the determination, applying the terms of the ETTP Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- In the case of a medical benefit claim, information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code, and the meaning of such codes);
- An explanation of how to request diagnosis and treatment codes (and their corresponding meanings);
- In the case of a medical benefit claim, available external review processes and the time limits; and
- In the case of a medical benefit claim, the contact information for any applicable consumer assistance office established under Section 2793 of the Public Health Service Act to assist you;
- In the case of a disability benefit claim, an explanation for any disagreement with and/or failure to follow the view regarding your disability of the Social Security Administration or any health care professionals who treated or evaluated you

- In the case of a disability benefit claim, a statement that the identity of any medical or vocational experts whose advice was obtained in connection with the denial, without regard to whether the advice was relied upon in making the denial determination, will be provided free of charge upon request

- In the case of a disability benefit claim, a statement that you are entitled to receive, upon request and free of charge, access to and copies of all documents, records or other information relevant to the determination.

You may request and receive, free of charge, reasonable access to and copies of relevant documents, records, and other information in the ETTP Plan's possession. Relevant documents, records, and other information are those that were relied on in making the benefit determination, were submitted/considered/generated in the course of making the benefit determination, demonstrate compliance with the ETTP Plan's or Benefit Option's administrative processes or safeguards, or in the case of a group health plan claim, constitute a statement of the ETTP Plan's or Benefit Option's policy or guideline regarding the benefits for your diagnosis, whether or not relied upon. In the case of a disability benefit claim, the denial notice will be culturally and linguistically appropriate and assistance will be available in any applicable non-English language, as required under ERISA.

External Review of Appeals Decision

Following a denial of a claim relating to you or your beneficiary's eligibility for benefits, you may also be entitled to initiate a claim for an external review under either state or federal external review procedures. This Plan intends to comply with the state and federal external review procedures, as applicable, and you will be provided with information describing your rights to file a request for an external review of a claim denial in accordance with these procedures, as applicable.

Finality of Review on Appeal

You will not be entitled to challenge the Plan Administrator's (or its designee's) determinations in judicial or administrative proceedings without first complying with these claims procedures. The decisions made pursuant to these procedures are final and binding on you, your beneficiaries, and any other party; provided, however, that if you have exhausted the claims procedures set forth in the ETTP Plan, you may seek review of your claim before a court of competent jurisdiction within twelve (12) months after the date your claim is finally denied. Notwithstanding any other provisions herein, any suit for benefits must be brought within twenty-four (24) months after the date the service or treatment was rendered.

Deemed Exhaustion

If the Plan Administrator (or its designee) fails to strictly adhere to all the requirements (except as noted below) for deciding claims and appeals in this section, you will be deemed to have exhausted the internal claims and appeals process and may initiate an external review or pursue litigation under Section 502(a) of ERISA. However, de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you shall not result in deemed exhaustion, provided that the violation was for good cause or due to matters beyond the control of the Plan Administrator (or its designee) and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the ETTP Plan.

BENEFIT OPTIONS

Medical Coverage

MEDICAL COVERAGE BENEFIT OPTION

Your medical coverage is a Benefit Option and key component of the ETTP Plan. This Benefit Option is a group health plan and pays benefits for the treatment of an illness or injury and offers many features, such as mental/behavioral health coverage, preventive health care coverage, well-baby care and prescription drug coverage. You should refer to your annual enrollment or new hire information, as applicable, for more information about the available Benefit Options that are offered by your employer for eligible active employees and eligible retirees.

You may choose medical coverage for yourself and your eligible dependents under the following coverage levels, if applicable:

- Single (or Employee Only)
- Dual (or Employee plus one other)
- Family (or Employee plus two or more others)

For questions and more information about your medical coverage, you may contact the Benefits Administrator at the contact information listed at the end of this SPD.

Certificates of Coverage

Your medical plan options are fully insured by an insurance carrier. The separate Certificates of Coverage provided by the insurance carrier will govern the terms of the insured medical plans and are incorporated into the terms of this SPD. The medical coverage under this ETTP Plan is described online at http://www.ucor.com/benefitsRMP.html. You may also request a paper copy of the medical certificate of coverage by contacting the Benefits Administrator or the Plan Administrator at the contact information listed at the end of this SPD.

Hospital Admissions for Maternity

The Newborns' and Mothers' Health Protection Act requires medical plans to provide a minimum hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a cesarean section unless the attending physician, in consultation with the mother, determines a shorter hospital length of stay is adequate.

Post-Mastectomy Care

If you or a covered dependent is receiving benefits in connection with a mastectomy and you or your covered dependent elect breast reconstruction, the medical program options also cover, in a manner determined in consultation with the attending physician and the patient:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Coverage for prosthetic devices and reconstructive surgery is subject to the same copayments and deductibles as those established for other benefits under the medical program options.

Medical Coverage

Health Savings Accounts

A Health Savings Account ("HSA") is a special savings account you own, and contribute to, for paying current and future medical expenses. An HSA is not offered by this ETTP Plan, but this ETTP Plan does offer a high deductible health plan that allows you to be eligible to contribute to an HSA, if you so desire.

The contributions to an HSA can be made on an after-tax basis and are tax deductible on your individual tax returns. Also, HSA withdrawals are tax-free if used for qualified medical expenses. If you were to ever terminate employment, the money in your HSA that you do not use to reimburse yourself for qualified medical expenses can remain in the HSA no matter where or if you are employed since the HSA is portable. Unlike a flexible spending account, HSA accounts can grow on a tax deferred basis through investment earnings. Unused savings can remain available for later years (unlike a flexible spending account where unused annual savings are forfeited each year).

HSAs are owned by the individual (not the employer). The individual decides whether he or she should contribute, how much to use for medical expenses, how must to use for personal expenses (subject to income tax and an excise tax), which medical expenses to pay from the account, whether the pay for medical expenses from the account or save the account for future use, which bank/trustee will hold the HSA account, and what type of investments to grow the account.

Each of the following factors must be met to be eligible for an HSA:

- You need to be participating in a high deductible health plan (HDHP), which this ETTP Plan offers. The HDHP cannot provide "first dollar coverage" until the annual deductible is met, except for certain preventive care, and the HDHP cannot utilize co-pays;

- You cannot be covered by another other comprehensive medical insurance. This includes coverage such as your spouse/partner's health insurance. However, you can be covered by your own or your spouse/partner's dental, vision, individual accident, cancer, ICU (excluding specified health event and critical illness), employee assistance program, and long-term care insurance;

- You cannot be covered by Medicare;

- You cannot be covered by your own or your spouse/partner's comprehensive healthcare flexible spending account; and

- IRS rules limits benefits for domestic partners.

You are eligible to contribute up to the amount shown in the annual enrollment materials, which will not exceed the IRS contribution limit. These limits may change in future years. For participants age 55 and older, an additional $1,000 HSA "catch-up" contribution is allowed. If you have a spouse who is also age 55 and covered by the HDHP and not covered by any other healthcare plan, you may contribute the "catch-up" amount for them as well. Spouse "catch-up" contributions must be deposited into a separate HSA account that they have established. Limitations exist for domestic partners. Contributions must stop once an individual is enrolled in Medicare. If you fail to remain an eligible individual during the entire 12-month period, all contributions made prior to the date you qualified for a HDHP will be included in gross income and subject to a 20% excise tax in the year in which you cease to be an eligible individual. Contributions to the HSA in excess of the contribution limits must be withdrawn (and any prorated earnings) by the individual or be subject to additional excise taxes.

The ACA permits health plans to extend coverage to adult children up to the age of 26 regardless of student status, marital status, etc., but this extension of coverage has no application to the HSA. This means that if the adult dependent child is NOT a tax qualified dependent of the employee, healthcare expenses of the adult dependent child are not reimbursable from the employee's HSA, even if the adult child is covered under the HDHP. If the adult dependent child covered under the HDHP is not a tax qualified dependent of the employee, he/she can open an HSA independently and also contribute to the HSA the amounts allowable for family coverage, and the adult dependent child can submit healthcare related expenses to his/her own HSA for reimbursement without penalty.

Medical Coverage

You may not contribute to both a healthcare flexible spending account and a HSA.

Dental Coverage

DENTAL COVERAGE BENEFIT OPTION

This ETTP Plan promotes preventive dental care and also provides benefits for corrective services. You should refer to your annual enrollment or new hire information, as applicable, for more information about the available Benefit Options that are offered by your employer for eligible active employees and eligible retirees.

You may choose dental coverage for yourself and your eligible dependents under the following coverage levels, if applicable:

- Single (Employee Only)
- Dual (Employee plus one other)
- Family (Employee plus two or more others)

See "Participation" for more details on who is considered an eligible dependent and when you can enroll yourself and/or your eligible dependents for dental coverage.

For questions and more information about your dental coverage, you may contact the Benefits Administrator at the contact information listed at the end of this SPD.

Certificates of Coverage

Your dental plan options are fully insured by an insurance carrier. The separate Certificates of Coverage provided by the insurance carrier will govern the terms of the insured dental plans and are incorporated into the terms of this SPD. These documents are available from the applicable insurance carrier or by contacting the Benefits Administrator at the contact information listed at the end of this SPD. The dental coverage under this ETTP Plan is described online at http://www.ucor.com/benefitsRMP.html.

Vision Coverage

VISION COVERAGE BENEFIT OPTION

Through this ETTP Plan, vision coverage may be elected. Please refer to your enrollment materials for more information. You should refer to your annual enrollment or new hire information, as applicable, for more information about the available Benefit Options that are offered by your employer for eligible active employees and eligible retirees.

You may choose vision coverage for yourself and your eligible dependents under the following coverage levels, if applicable:

- Single (Employee Only)
- Dual (Employee plus one other)
- Family (Employee plus two or more others)

See "Participation" for more details on who is considered an eligible dependent and when you can enroll yourself and/or your eligible dependents for coverage.

For questions and more information about your vision coverage, you may contact the Benefits Administrator at the contact information listed at the end of this SPD.

Certificates of Coverage

Your vision plan options are fully insured by an insurance carrier. The separate Certificates of Coverage provided by the insurance carrier will govern the terms of the insured vision plans and are incorporated into the terms of this SPD. These documents are available from the applicable insurance carrier or by contacting the Benefits Administrator at the contact information listed at the end of this SPD. The vision coverage under this ETTP Plan is described online at http://www.ucor.com/benefitsRMP.html.

Long Term Disability Coverage

LONG TERM DISABILITY COVERAGE BENEFIT OPTION

If you become disabled from a non-work-related injury or illness and cannot work, this Benefit Option helps you meet the challenge by offering long-term disability ("LTD").

You should refer to eligibility table in the Participation section of this SPD for more information about this Benefit Option and whether it is offered by your employer.

For questions and more information about your LTD coverage, you may contact the Benefits Administrator at the contact information listed at the end of this SPD.

Certificates of Coverage

This LTD coverage is fully insured by an insurance carrier. The separate Certificates of Coverage provided by the insurance carrier will govern the terms of the insured LTD coverage and are incorporated into the terms of this SPD. These documents are available from the applicable insurance carrier or by contacting the Benefits Administrator at the contact information listed at the end of this SPD. The long-term disability coverage under this ETTP Plan is described online at http://www.ucor.com/benefitsRMP.html.

Life Insurance Coverage

LIFE INSURANCE BENEFIT OPTIONS

The ETTP Plan's life insurance Benefit Options provide financial protection for you and your family in the event of a death. The life insurance program consists of: optional Basic Life Insurance, optional Supplemental Life Insurance, and optional Dependent Life Insurance. Please refer to the eligibility table in the Participation section of the SPD for benefit options offered by your employer for eligible active employees and eligible retirees.

- Basic Life Insurance (optional): Provides a benefit to your survivors in the event of your death.
- Optional Supplemental Life Insurance: Provides an additional benefit to your survivors in the event of your death.
- Optional Dependent Life Insurance: Provides a benefit to survivors in the event of the death of your spouse or child.

Tax Alert

If your Basic Life Insurance coverage does not exceed $50,000, the coverage is tax free to you. However, if your Basic Life Insurance coverage exceeds $50,000, you must include in your gross income the cost of the excess coverage that is paid by your employer. For this purpose, the cost is computed using a uniform premium table published by the Internal Revenue Service and is reported to you as imputed income on your Form W-2 ("C" in Box 12) and on your paycheck.

Evidence of Insurability

In some instances, you may be required to provide Evidence of Insurability ("EOI") for your elected life insurance coverages. This may require that you or your spouse pass a thorough physical examination. Coverage in excess of the amount subject to EOI will only become effective when the insurance company approves the EOI. This means that if you enroll for any life insurance that requires EOI at annual enrollment, coverage will become effective at the later of January 1 or the insurance company's approval of EOI. If you are on a leave of absence during annual enrollment, you will not be able to add or increase your life insurance coverage for yourself or any dependent during annual enrollment. Instead, you may make a new election to add or increase coverage during the 30-day period that begins on the day you return to work. You must contact the Benefits Center to make this change to your coverage. The election you make during this 30-day period will become effective on the later of the date you return to work or the date the insurer approves any required EOI.

Certificates of Coverage

Your life insurance options are fully insured by an insurance carrier. The separate Certificates of Coverage provided by the insurance carrier will govern the terms of the insured life insurance coverages and are incorporated into the terms of this SPD. These documents are available from the applicable insurance carrier or by contacting the Benefits Administrator at the contact information listed at the end of this SPD. The life insurance coverage under this ETTP Plan is described online at http://www.ucor.com/benefitsRMP.html.

GENERAL INFORMATION

General Information

PLAN ADMINISTRATION

The ETTP Plan Administrator has the sole and complete discretionary authority to determine eligibility for ETTP Plan benefits and to construe the terms of the ETTP Plan, including the making of factual determinations. The ETTP Plan Administrator shall have the discretionary authority to grant or deny benefits under the ETTP Plan. Benefits under the ETTP Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. The decisions of the Plan Administrator shall be final and conclusive with respect to all questions relating to the ETTP Plan. If a Claims Administrator has the only review authority, the Claims Administrator's decision will be final and conclusive with respect to all questions.

The ETTP Plan Administrator may delegate certain of its ETTP Plan duties to other persons and may seek such expert advice as the Plan Administrator deems reasonably necessary with respect to the ETTP Plan. The ETTP Plan Administrator shall be entitled to rely on the information and advice furnished by such delegates and experts, unless actually knowing such information and advice to be inaccurate or unlawful.

The ETTP Plan Administrator may adopt uniform rules for the administration of the ETTP Plan from time to time, as it deems necessary or appropriate.

Amendment and Termination

UCOR, as the ETTP Plan Sponsor, and the Benefits and Investment Committee (BIC), as the Plan Administrator, reserve the sole discretionary right to modify, amend or terminate the ETTP Plan, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by the Amendment Committee, UCOR's Board of Directors, UCOR's Board of Managers, UCOR's President and Project Manager, or its designee.

UCOR's decision to change or terminate the ETTP Plan could result from:

- Changes in federal or state laws governing employee benefits;
- Changes in an insurance contract or policy involving an insurance company;
- Changes in a collective bargaining agreement; or
- Any other reason.

If the ETTP Plan is modified, amended or terminated, you will be notified of the effect of such change to your Plan benefits or coverage. However, the modification, amendment or termination may be effective before you are notified, to the extent permitted by law. Subject to the terms of any collective bargaining agreement or applicable law, no consent of any employee or any other person will be necessary for UCOR to modify, amend or terminate the ETTP Plan described in this SPD.

Representations Contrary to the ETTP Plan

No employee, director or officer of UCOR, or Participating Employer has the authority to alter, vary or modify the terms of the ETTP Plan except by means of a duly authorized written amendment to the ETTP Plan. No verbal or written representations contrary to the terms of the ETTP Plan are binding upon the ETTP Plan, the Plan Administrator or your employer.

No Assignment

To the extent permitted by law, and except as specified under the terms of the ETTP Plan, no benefits will be subject to alienation, sale, transfer, assignment, garnishment, execution or encumbrance of any kind, and any

attempt to do so will be void. However, benefits under the ETTP Plan may be subject to a Qualified Medical Child Support Order (QMCSO).

Recovery of Benefit Payments Made by Mistake

You will be required to return to the ETTP Plan any benefits, or portion thereof, paid under the ETTP Plan by a mistake of fact or law. If you do not return benefits paid under the ETTP Plan by a mistake of fact or law, the ETTP Plan may offset your future benefits up to the amount you owe the ETTP Plan.

Recovery of Premiums in Arrears

You may be required to remit payment of premiums in arrears for time periods in which you received benefits under one or more Benefit Options in this ETTP Plan.

Undispursed Funds

Any benefit payments that remain outstanding (*e.g.,* uncashed checks) after 12 months shall be forfeited by the participant or dependent. Such forfeited amounts shall be used to pay plan administrative expenses or for such other use permitted under applicable law. If a participant or dependent entitled to benefits returns and claims such benefit payment within two years of the forfeiture date, such amount shall be paid as soon thereafter as administratively feasible.

Responsibility for Tax Implication of Benefits

You will be responsible for the tax implications of and determination of imputed income with respect to any benefits you elect for eligible dependents who are not entitled to tax-free benefits under current federal law.

No Contract of Employment or Service

Your participation in the ETTP Plan does not assure you of continued employment with your employer or rights to benefits except as specified under the terms of the ETTP Plan. Nothing in the ETTP Plan or in this SPD confers any right of continued employment (or service, as applicable) to any employee or leased employee, as applicable.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the ETTP Plan described in this SPD to be void, unlawful or unenforceable under any applicable statute or other controlling law, the remainder of the ETTP Plan shall continue in full force and effect.

Plan Funding

Benefits offered under the ETTP Plan are provided on either a self-insured basis by the Participating Employer or are fully insured through an insurance policy. Please see the “Plan Information” chart at the end of this section for more details on which third-party administrators and insurance companies provide services and benefits.

Applicable Law

The ETTP Plan described in this SPD shall be governed and construed in accordance with the laws of the state of Tennessee to the extent not preempted by the laws of the United States.

General Information

Governmental Benefits Exclusion

If services or benefits are reasonably available under any plan or program established by any government or under any plan or program in which any government participates (other than as an employer), benefits under the ETTP Plan are not payable for such services or benefits unless payment is legally required. In the case of any person who is not enrolled for all coverage for which he or she has become eligible under any such plan or program, services and benefits available shall nevertheless include all benefits to which he or she would be entitled if he or she were enrolled for such coverage. The term "any government" includes the federal, state, provincial or local government or any political subdivision thereof of the United States or any country. This provision is subject to any provision or regulation of such plan or program that requires that benefits be utilized before benefits are available thereunder.

Interpretive Authority

If the ETTP Plan document does not clearly dictate whether an expense is eligible under the ETTP Plan and/or what percentage of the eligible charge is covered, the Claims Administrator or insurer will make a determination and pay benefits accordingly. Except as provided above, if a question arises as to the interpretation of the terms of the ETTP Plan document, the Plan Administrator has discretionary authority to interpret, construe and apply the terms of the ETTP Plan document and to decide any such question, including but not limited to a question as to an eligible employee's eligibility to participate in the ETTP Plan.

Statement of ERISA Rights

As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you are entitled to:

Receive Information About Your Plan and Benefits

- Examine without charge at the Plan Administrator's location all Plan documents, including insurance contracts, and copies of all documents filed by the ETTP Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as annual financial reports (Form 5500 Series).

- Obtain copies of documents governing the operation of the ETTP Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated SPD upon written request to the Plan Administrator (at the address below). The ETTP Plan Administrator may make a reasonable charge for the copies.

- Receive summaries of the ETTP Plan's annual financial reports. These summaries are prepared and distributed to Plan participants each year. The ETTP Plan Administrator is required by law to furnish each participant a copy of the summary annual report.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this SPD and the documents governing the ETTP Plan regarding the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the ETTP Plan. The people who operate the ETTP Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

General Information

No one, including your employer or any other person, may discharge you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the ETTP Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the ETTP Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the ETTP Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance With Your Questions

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

GENERAL INFORMATION

Plan Sponsor	URS | CH2M Oak Ridge LLC P.O. Box 4699 MS 7402 Oak Ridge, TN 37831 865-576-9206 Employer Identification Number: 45-2178216
Plan Administrator	Benefits and Investments Committee P.O. Box 4699 MS 7402 Oak Ridge, TN 37831 865-576-9206 You may obtain a copy of any of the official legal documents from the Plan Administrator at the above address.
Agent for Legal Service	CT Corporation System 300 Montvue Road Knoxville, Tennessee 37919 Service of legal process may also be made on the Plan Administrator.
Plan Name **Plan Number** **Plan Year**	East Tennessee Technology Park Health and Welfare Benefit Plan Plan No. 510 January 1 – December 31
Plan Type	This Plan is an employee welfare benefit plan offering group health, disability and life coverages to eligible employees and eligible retirees of Participating Employers.
Type of Administration	The type of administration depends upon the particular Benefit Option. If the Benefit Option is insured, then it is administered by the insurer. If the Benefit Option is self-insured, then it is administered by the Benefits Investment Committee as the Plan Administrator or its delegate.
Named Fiduciary (for Benefit Claims)	The ETTP Plan Administrator is hereby designated as the "named fiduciary," within the meaning of ERISA Section 402(a), with respect to the operation and administration of the ETTP Plan and is responsible, except to the extent provided hereof, for administering the ETTP Plan in accordance with its terms. For each of the insured Benefit Options, the insurance company is a "named fiduciary" with respect to decisions regarding whether a claim for benefits will be paid under the insurance contract.
Benefits Administrator (third party administrator delegated by the Plan Administrator)	Mercer Single Source 1 1-888-890-5631 www.hrbenefitsadvantage.com

Questions regarding your benefits or this SPD should be addressed to the Benefits Administrator.

PLAN INFORMATION

Benefit Option	Funding	Contact Information
Medical	Fully insured insurance contract with Aetna	Aetna 1-888-238-6203 www.aetna.com
Dental	Fully insured insurance contract with Cigna	Cigna 1-800-244-6224 www.mycigna.com
Vision	Fully insured insurance contract with Vision Service Plan Insurance Company	Vision Service Plan Insurance Company ("VSP") 1-800-877-7195 www.vsp.com
COBRA Administrator	Not Applicable	Discovery Benefits 1-866-451-3399
Long-Term Disability	Fully insured insurance contract with Unum Life Insurance	Unum 1-800-421-0344 www.unum.com/claims
Basic Life Insurance **Supplemental Life Insurance** **Dependent Life Insurance**	Fully insured insurance contract with Securian Life Insurance	Securian 1-888-658-0193

APPENDIX A
WELFARE BENEFITS

(as of January 1, 2019)

The following Benefit options are available under the ETTP Plan to eligible employees and eligible retirees:

(a) Medical Insurance[3]

(b) Dental Insurance[2,3]

(c) Vision Insurance[2,3]

(d) Long-Term Disability Insurance[1,4]

(e) Basic Employee Life Insurance[2,4]

(f) Employee Supplemental Life Insurance[2,4]

(g) Spouse Life Insurance[4]

[1] Pursuant to the Adoption Agreement in place with Fluor-BWXT Portsmouth and Portsmouth Mission Alliance LLC (which adopted the ETTP Plan as of April 25, 2016), long-term disability insurance is not available to eligible Employees of Fluor-BWXT Portsmouth and Portsmouth Mission Alliance LLC.

[2] Eligible pre-65 retirees may elect dental and vision benefits under the ETTP Plan. Eligible pre-65 retirees may also cover their eligible spouses who are pre-65 or over age 65. Eligible post-65 retirees may cover their eligible spouses who are pre-65. Eligible pre-65 and post-65 retirees are eligible for life insurance. If you are a retiree, you are only eligible for the ETTP Plan if you are eligible to enroll in the East Tennessee Technology Park Retiree Medical Benefit Plan.

[3] Only available to certain union employees at Fluor-BWXT Portsmouth LLC, Portsmouth Mission Alliance LLC, Four Rivers Nuclear Partnership, LLC and Wastren Advantage, Inc. (subcontractor to Four Rivers) for whom the collective bargaining agreement requires participation in the ETTP Plan.

[4] May require after-tax contributions