Summary Plan Description

URS | CH2M OAK RIDGE LLC
Health and Welfare Benefit Plan

(effective January 1, 2019)

Summary Plan Description updated January 1, 2019

This Summary Plan Description ("SPD") summarizes the major features of the benefits program for eligible participants under the URS | CH2M OAK RIDGE LLC Health & Welfare Benefit Plan (the "UCOR Plan" or the "Plan") as of January 1, 2019. You should also refer to any applicable cover letter accompanying this SPD for changes and additions to the SPD.

As of January 1, 2019, this SPD applies to eligible employees of URS | CH2M OAK RIDGE LLC ("UCOR").

You should not rely on the information in this SPD other than as a general summary of the features of the URS | CH2M OAK RIDGE LLC Health and Welfare Benefit Plan (the "UCOR 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 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 UCOR's records. For this reason, it is important that you notify the UCOR Benefits Administration Department or its third party administrator when you have a change of address. You should also keep announcements and notices with this booklet for your future reference.

The UCOR Plan is effective January 1, 2019. The UCOR 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 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 1974.

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WHAT'S INSIDE

This SPD contains important information on many of the benefit programs offered under the URS | CH2M OAK RIDGE LLC Health and Welfare Benefit Plan (the "UCOR Plan" or the "Plan"). Please read it carefully and maintain in your records.

AN OVERVIEW OF YOUR HEALTH AND WELFARE BENEFITS

The UCOR 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 Plan are listed below and described throughout this SPD. Eligibility criteria may also vary for each Benefit Option. You may participate in the following Benefit Options as an eligible employee.

- Medical Coverage
- Dental Coverage
- Vision Coverage
- Accidental Death and Dismemberment (AD&D) or Special Accident Insurance for certain eligible employees
- Employee Assistance Program (EAP) and work/life benefit
- Business Travel Accident Insurance
- Health Care Flexible Spending Accounts
- Dependent Care Flexible Spending Accounts

The UCOR Plan does not pay your bills or pay you any cash benefits. Rather, the benefits provided by the UCOR Plan, (except for the Health Care Flexible Spending Account and the Dependent Flexible Spending Account offered to UCOR employees), 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 UCOR ceases to pay premiums on an insurance contract for any reason, your coverage under that insurance contract 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 administering the various Benefit Options under the 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 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 UCOR's benefits department with the Plan's insurers and third party administrators is to assist you with questions you may have about this Plan. However, statements made by such representatives do not have a binding effect on the UCOR Plan. If you need to bring or appeal a claim under this 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 Plan Sponsor, and the UCOR Amendment Committee, as the Plan Administrator, reserve the sole discretionary right to modify, amend, suspend, or terminate the Plan, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by the UCOR Amendment Committee, UCOR's Board of Managers, UCOR's President and Project Manager, or its designee.

UCOR's decision to change or terminate the UCOR 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 UCOR Plan is modified, amended or terminated, you will be notified of the effect of such change to your UCOR 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 UCOR Plan described in this SPD.

PARTICIPATION

Participation

YOUR ELIGIBILITY

Generally, you are eligible for health and welfare benefits available under applicable Benefit Options as set forth below.

UCOR HEALTH AND WELFARE BENEFIT PLAN ELIGIBLE EMPLOYEE BENEFITS	BENEFITS						
	MEDICAL	DENTAL	VISION	FLEXIBLE SPENDING (FSA)	AD&D	EAP	BUSINESS TRAVEL
UCOR SALARIED							
Active Full Time and Part Time	√	√	√	√	√	√	√
Salaried LTD	√	√	√				
Salaried COBRA	√	√	√	√		√	
Salaried Displaced Worker Medical Benefit	√						
UCOR USW BARGAINING UNIT							
Active USW Full Time and Part Time	√	√	√	√	√	√	√
USW LTD	√	√	√				
USW COBRA	√	√	√	√		√	
USW Displaced Worker Medical Benefit	√						
UCOR ATLC-ORNL BARGAINING UNIT							
Active ATLC ORNL Full Time and Part Time	√	√	√	√	√	√	√
ATLC ORNL LTD	√	√	√				
ATLC ORNL COBRA	√	√	√	√		√	
ATLC ORNL Displaced Worker Medical Benefit	√						
Active ATLC Y-12 Full Time and Part Time	√	√	√	√	√	√	√
ATLC Y-12 LTD	√	√	√				
ATLC Y-12 COBRA	√	√	√	√		√	
ATLC Y-12 Displaced Worker Medical Benefit	√						
UCOR INTERN	√					√	√

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

Participation

You are NOT eligible for health and welfare benefits under this Plan if UCOR is required under a collective bargaining agreement (or another related participation agreement) to make contributions to a plan offering similar coverage for you and your dependents.

If you are an eligible employee and receive disability income benefits pursuant to the terms of a short-term or long-term disability program maintained by UCOR, 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 the UCOR 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 UCOR Plan immediately prior to an illness or injury for which you have timely applied for, and are awaiting approval of, disability benefits under a UCOR-sponsored short-term or long-term disability program.

YOUR ENROLLMENT

Beginning of Coverage

Participation in the UCOR Plan does not begin unless you actually enroll, except for certain coverages that are provided automatically. If you are a newly hired employee, you will receive enrollment information from UCOR, including an enrollment notice. The deadline for new hire enrollment in the UCOR 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.

YOUR ELIGIBILE DEPENDENTS

Subject to certain limitations, your eligible dependents may also participate in the UCOR 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 Plan prior to attaining age 26 (or another limiting age under applicable state laws). The child must be determined to be disabled by the Social Security Administration to qualify for continued coverage beyond age 26.

Participation

- ✓ A child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO);
- ✓ 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., the Dependent Care Flexible Spending Account, Accidental Death and Dismemberment insurance and Business Travel Accident 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.

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's 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 UCOR Plan's terms. If you are identified as covering ineligible dependents, you may be subject to legal action and discontinued from UCOR 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 UCOR 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 UCOR to cover a child as your dependent under the UCOR Plan for medical coverage. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid.

If the UCOR 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 UCOR Plan as both a participant and a dependent. Also, no person may be covered as a dependent of more than one participant in the UCOR Plan, except with respect to the Special Accident Insurance Benefit Option.

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

You may prospectively revoke your election for medical coverage under the UCOR 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 UCOR 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 UCOR under this 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 UCOR 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 UCOR, 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 UCOR's plan, UCOR must allow you to enroll in the 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 UCOR 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. You should check with UCOR's Benefits Administration 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.

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.

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 Plan, your pre-tax contributions to the 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 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 UCOR Plan.

Please note: Coverage under the UCOR 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, UCOR cannot assure you that it will be to your advantage to participate in the UCOR Plan on a pre-tax or after-tax basis.

ENROLLMENT

Enrollment Opportunities

The UCOR 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
- 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).

Participation

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, UCOR 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.

IMPORTANT: For UCOR employees who want to participate in the Health Care and Dependent Care Flexible Spending Accounts as a Benefit Option, you will need to make an election for each Plan year in which you wish to participate in these programs. Your elections for these Benefit Options **will not** automatically continue from Plan year to Plan year, even if the annual enrollment is "passive" for other benefits. During annual enrollment, you must enroll for coverage and authorize the amount you want to deduct from your gross pay on a pre-tax basis, subject to certain maximums and IRS regulations.

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.

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 UCOR 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 participate in the UCOR Plan for the next plan year beginning on January 1st.

Special Circumstances: Re-employment

If you leave UCOR and subsequently return to work for UCOR, the following rules will apply:

- 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 Plan year following the Plan year in which you terminated employment, you will need to make new coverage elections.

Participation

If you terminate and are rehired in the same year, special rules will apply to reimbursements from your Health Care Flexible Spending Account. For more information, see "How Your Flexible Spending Accounts Work" in the "Flexible Spending Accounts" section of this SPD.

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.

UCOR 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 UCOR'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.

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 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 UCOR 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.

Participation

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 UCOR's Benefits Administration Department.

Coverage During Unpaid Absences

In the event you qualify for an unpaid leave of absence under UCOR'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 UCOR's Benefits Administration 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 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 UCOR's Benefits Administration Department.

Furlough Periods

A "furlough period" means a period of furlough implemented by UCOR 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, UCOR, 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.

Participation

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 UCOR Plan.

WHEN COVERAGE ENDS

Your Coverages End

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

- Your employment with UCOR 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 Plan Sponsor, UCOR, terminates the Benefit Option in whole or in part;
- Coverage is terminated for the eligible class to which you belong.

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 in a timely manner;
- When your coverage ends;
- Your dependent no longer meets the eligibility requirements; or
- You cease to be a participant in this UCOR Plan.

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 UCOR 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 vision 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 UCOR Plan are made on the condition that you will reimburse this 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 Plan. The "make whole doctrine" arising under Federal common law and under State law does not apply to this Plan's reimbursement or subrogation rights. The Plan Administrator, in its sole discretion, may determine to reduce the reimbursement to the UCOR Plan from you by attorneys' fees and other expenses paid by you during your recovery against a third-party.

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. For UCOR eligible employees only, COBRA is also available for you and your covered dependents to continue the Health Care FSA coverage on an after-tax basis in certain situations 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, UCOR-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 UCOR 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.

UCOR 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	You and your enrolled dependents	18 months up to 29 months***

become disabled		
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 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).

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
- UCOR 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.

Administration

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.

Health Care Flexible Spending Account ("Health Care FSA")

If you participated in the Health Care FSA as an eligible active employee of UCOR, you and your covered dependents are also permitted to elect COBRA continuation coverage for the Health Care FSA upon a qualifying event, provided you have not received reimbursement for amounts that exceed the balance in your Health Care FSA as of the date the qualifying event occurs (i.e., you have not "overspent" your Health Care FSA). In this case, you would continue contributions on an after-tax basis. The COBRA rules discussed in this section are the same, except that the maximum period for which you may continue after-tax contributions to your Health Care FSA is the remainder of the Plan year in which the qualifying event occurs.

Administration of COBRA

If you have any questions about COBRA or if you are required to notify UCOR 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 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

CLAIMS AND APPEALS

This section reviews what you need to do to file claims for the different Benefit Options in the 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 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 Plan Administrator, generally determines these types of claims. 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 or, with respect to the Health or Dependent Care FSAs, a request that expenses be reimbursed. 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 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 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 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 Claims: When a claim is received that is not a medical 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 Medical: When a medical benefit claim is received that is a Pre-Service claim (as defined below) that is not an Urgent Care claim (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 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 Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. 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 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 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 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 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 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 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 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 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 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 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 Plan will provide for the identification of medical or vocational experts whose advice was obtained on behalf of the 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 Plan Administrator will furnish you with a written decision providing the final determination of the claim. The 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 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 Plan's appeal procedures and the time limits applicable to the appeal process;
- 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.

You may request and receive, free of charge, reasonable access to and copies of relevant documents, records, and other information in the 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 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 Plan's or Benefit Option's policy or guideline regarding the benefits for your diagnosis, whether or not relied upon.

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 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.

BENEFIT OPTIONS

Medical Coverage

MEDICAL COVERAGE BENEFIT OPTION

Your medical coverage is a Benefit Option and key component of the 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 may choose medical coverage for yourself and your eligible dependents under the following coverage levels:

- 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 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.

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 Plan, but this Plan does offer a high deductible health plan that allows you to be eligible to contribute to an HSA, if you so desire.

Medical Coverage

The contributions to an HSA can be made on a pre-tax basis. 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 much 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 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; and

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

IRS rules limit 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.

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

Medical Coverage

You are free to choose any HSA provider. You can locate HSA institutions at http://hsafinder.com. There may be fees involved with establishing an HSA with an HSA administrator.

More information about HSAs can be found in IRS Publication 969 titled, “Health Savings Accounts and Other Tax-Favored Health Plans” found at www.irs.gov. The summary of HSAs contained in this SPD is intended to be a brief overview and is not to be relied upon for detailed information for your specific situation.

Dental Coverage

DENTAL COVERAGE BENEFIT OPTION

This Plan promotes preventive dental care and also provides benefits for corrective services.

Generally, the available coverage levels are listed below:

- 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 Plan is described online at http://www.ucor.com/benefitsRMP.html.

Vision Coverage

VISION COVERAGE BENEFIT OPTION

Through this Plan, vision coverage may be elected. Please refer to your enrollment materials for more information.

Generally, the available coverage levels are:

- 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 Plan is described online at http://www.ucor.com/benefitsRMP.html.

Business Travel

BUSINESS TRAVEL ACCIDENT INSURANCE COVERAGE BENEFIT OPTION

Business Travel Accident Insurance pays benefits in the event of accidental dismemberment or death while traveling on your employer's business if the loss occurs within 365 days of the accident. The travel must be away from your regular place of employment and at your employer's authorization, direction, and expense. Business travel may include travel or activities that are unrelated to business and which take place away from your residence or regular place of employment as long as such travel or activity coincides with your business travel and is limited to any consecutive seven-day period immediately prior to, during or immediately following your business travel. This does not include commuting to and from work.

Certificates of Coverage

Your Business Travel Accident Insurance 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 Business Travel Accident 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 business travel accident coverage under this Plan is described online at http://www.ucor.com/benefitsRMP.html.

Special Accident Insurance or Accidental Death and Dismemberment

SPECIAL ACCIDENT INSURANCE BENEFIT OPTION

This Plan offers Accidental Death and Dismemberment ("AD&D"). (Note that AD&D is sometimes also called "Special Accident Insurance.") AD&D Insurance is available for purchase and pays benefits for a death or dismemberment occurring within 365 days of, and resulting from, a covered accident while your coverage is in effect. You must elect AD&D coverage because enrollment is not automatic.

Certificates of Coverage

Your Special Accident 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 Special Accident 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 AD&D coverage under this Plan is described online at http://www.ucor.com/benefitsRMP.html.

Employee Assistance Program Coverage

OVERVIEW OF THE EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program ("EAP"), currently offered through Aetna's Resources for Living, provides a wide range of resources and information to help you balance your work and personal life. A simple toll-free call can connect you with a trained counselor who can provide assistance with a wide range of issues. The EAP is available to eligible employees at no cost.

ACCESSING SERVICES

You and the members of your immediate family (spouse and dependents) may utilize the EAP services immediately upon employment if you are an eligible employee of UCOR.

You and your family members can access EAP by phone or the internet 24 hours a day, 7 days a week. For phone access, simply call toll-free 1-888-238-6232. Internet access is at www.resourcesforliving.com. A user name and password are provided to eligible employees.

COUNSELING SERVICES

EAP's Guidance Consultants are available to help you with a variety of concerns, including:

- Marital and family conflicts
- Grief and loss
- Drug and alcohol abuse
- Anxiety and stress
- Eating disorders
- Physical or emotional abuse

Eligible employees, members of their household, and adult children (up to the age of 26) can each receive up to five (5) face-to-face counseling sessions each year at no direct cost.

When you call, an EAP Guidance Consultant will listen to your concerns and refer you to a professional in your area. During your scheduled appointment, an experienced EAP counselor will discuss your situation and help you develop a solution-focused plan of action.

LEGAL SERVICES

Eligible employees also receive ½ hour free consultation with selected attorneys for various legal topics such as general law (excluding employment law), special needs, and emergency matters. A discount of 25% off the hourly rate for selected attorneys is available to eligible employees for services not covered or beyond the initial ½ hour consultation.

FINANCIAL SERVICES

Eligible employees receive ½ hour free consultation each year on new financial counseling topics, such as budgeting, credit, debt, retirement, college funding, buying or leasing, mortgages/refinancing, financial planning, tax matters, and other IRS matters. Eligible employees also receive a discount of 25% off the tax preparation services with selected advisors.

Employee Assistance Program Coverage

IDENTIFY THEFT

Eligible employees receive one hour consultation of telephonic fraud resolution as well as coaching and direction on prevention and restoring credit for victims of identity theft.

WORK LIFE SERVICES

Eligible employees and their household members can access a wide range of services, including consultation, information, education, and referral services in connection with child care, elder care, care for people with disabilities, caregiver support, urgent/daily living needs, adoption, school/college planning, parenting, pet care, special needs, summer care, and temporary back-up care.

Flexible Spending Accounts

OVERVIEW OF YOUR FLEXIBLE SPENDING ACCOUNTS

UCOR offers its employees a way to pay certain health care and dependent care expenses with pre-tax dollars through two types of Flexible Spending Accounts (the "FSAs") — a Health Care FSA and a Dependent Care FSA. This section only applies to the FSAs offered as a Benefit Option by UCOR.

As you read about the FSAs, keep the following in mind:

- Each year at annual enrollment, you decide whether or not to use one or both of the FSAs and how much to contribute during the upcoming year. Because your contributions are not considered taxable, you may want to consider whether an FSA can help you pay less in taxes in an upcoming year.

- You make contributions to your FSAs through authorized pre-tax salary deductions. These contributions remain in your FSAs until you file an appropriate claim form for reimbursement or pay for health care expenses using your PayFlex Debit Card (or until they are forfeited after the end of the year). After filing a claim form, you are reimbursed for eligible expenses with tax-free dollars from the appropriate FSA.

- If you have any money left in either FSA at the end of the year, you can submit claims incurred through March 15 of the following year (the "grace period") to be reimbursed from the prior year's balance.

- If, at the end of the year and its grace period, there are funds remaining in either FSA for which you do not submit a timely claim form, you forfeit those amounts as required by Internal Revenue Service (IRS) regulations.

A Snapshot of Your Flexible Spending Accounts

By using pre-tax dollars to pay certain eligible health care and dependent care expenses, you may save some taxes each year. Here is a snapshot of the Health Care and Dependent Care FSAs.

	Health Care FSA	Dependent Care FSA
Eligible Expenses	Generally, medical, prescription drug, dental, vision and hearing expenses not eligible for reimbursement from any other source, but are otherwise tax deductible*	Eligible Dependent care expenses you incur while you and your spouse, if any, are at work
Qualified Dependents	Your eligible dependents under the Plan	A child under age 13 Any dependent that is incapable of self-care that resides with you and that you claim as a dependent on your tax return
Maximum Annual Contribution	Established each year by the plan administrator	$5,000 ($2,500 if married, but file federal income tax return as a single individual)***

***To satisfy the requirements of federal law, highly compensated employees (those who earned over $120,000 in 2018) are not eligible to participate in the Dependent Care FSA.

HOW YOUR FLEXIBLE SPENDING ACCOUNTS WORK

If you are an employee of UCOR and decide to participate in one or both of the FSAs offered to UCOR's eligible employees, the Plan Administrator will establish one or two accounts, as applicable, in your name. Your FSA is a bookkeeping account only; so no actual funds are segregated for this benefit. The Health Care and Dependent Care FSAs generally work in the same manner, but they are two separate accounts that are subject to some different rules and restrictions. In addition, amounts credited to your Health Care FSA may not

be used to reimburse you for your Dependent care expenses, and amounts credited to your Dependent Care FSA may not be used to reimburse you for your health care expenses.

What You Need to Do

To make the FSAs work for you, follow these steps:

- Estimate your expenses
- Consider your estimate carefully because you forfeit any unused amounts left in your FSAs under the IRS's "use-it-or-lose-it" rule
- Determine how much to contribute
- After you decide on the annual dollar amount (subject to each FSA's maximum) for your estimated expenses, you will make a separate election for each FSA
- Incur expenses
- The FSAs reimburse enrolled participants for eligible expenses they or their dependents incur during the Plan year (January 1 through December 31) and until the following March 15 (the "grace period")
- Receive reimbursement

You can use your Health Care FSA to pay for eligible health care expenses by using your PayFlex Debit Card or by seeking reimbursement for expenses you paid directly. For eligible Dependent care expenses, you must pay the service provider and then seek reimbursement from your Dependent Care FSA. See "Using Your PayFlex Debit Card" at the end of this FSA Section for more information about the PayFlex Debit Card.

If You Terminate Employment

Only the expenses incurred while you are an active eligible employee and contributing to the FSAs are eligible for reimbursement, unless, with respect to the Health Care FSA only, you continue your participation through COBRA. (See "Medical Coverage Continuation Rights" in the "Participation" section of this handbook for more details.)

If you terminate employment and are rehired within the same year, special rules apply to your new Health Care FSA contributions. If when you terminated you had received reimbursements totaling more than you contributed for the year, any new contributions made when you are rehired will first be used to reimburse the Plan for the excess payments made to you earlier in the year.

If You Return from a Leave of Absence

If you go on a paid leave of absence, your contributions to the Health Care FSA will continue. If you go on an unpaid leave of absence, you may continue contributions on an after-tax basis by submitting payments to the COBRA Administrator. By continuing contributions, expenses incurred during the leave will be reimbursable, if they are eligible expenses (Dependent Care FSA expenses are likely not reimbursable expenses if incurred during a leave. See the Dependent Care FSA section below for more information).

If you choose not to continue coverage in your FSAs during your leave of absence, upon your return you can choose to:

- Reinstate your per pay period deduction amount, or
- Adjust your per-pay-period deduction to meet your elected annual contribution.

In either case, you will not be able to receive reimbursement from your FSAs for eligible expenses incurred during your leave of absence (unless you elect COBRA coverage). As discussed below, any PayFlex Debit Card will be deactivated during an unpaid leave.

Flexible Spending Accounts

If you begin your leave of absence in one plan year and return in a later plan year, you must make new FSA elections within 31 days of your return to work.

"Use-It-or-Lose-It" Rules

Tax laws require that all amounts that you contribute to your FSA during the year be used to reimburse eligible expenses that you incur during the same year. If you overestimate your expenses, the tax laws require that any unused pre-tax contributions be forfeited.

As an exception to this requirement, the FSAs offer a grace period that automatically extends the coverage period of all participants who are covered on the last day of the Plan year (December 31). You have until March 15 of the new year to **incur** claims for reimbursement from your prior year's FSA. Any claims or provider payments that cover expenses incurred during the grace period will be automatically paid out of the prior Plan year's account first and then, when that account balance is exhausted, the new Plan year account.

You have until March 31 of the next year to **submit** claims for reimbursement from your FSAs for eligible expenses incurred between the previous January 1 and December 31 and during the grace period. Once this deadline passes, you will forfeit any balance remaining in your FSA after all proper claims have been submitted and paid.

Uniform Coverage Rule

For the Health Care FSA, you are entitled to reimbursement for eligible expenses for the full amount of your annual election as of your first day of coverage. This is called the "uniform coverage rule". You will continue to be reimbursed for eligible expenses until your total reimbursements equal the annual amount you elected to contribute to your Health Care FSA.

The uniform coverage rule does not apply to your Dependent Care FSA. As you submit claims for eligible expenses, you will be reimbursed for all proper claims up to the actual amount that is credited to your Dependent Care FSA when the claim is received. If the balance in your Dependent Care FSA is less than the amount of a claim, the claim will be held and reimbursed after additional contributions sufficient to cover the claim have been credited to your Dependent Care FSA.

A Word About Taxes

FSA contributions reduce your taxable income – meaning you pay less in taxes. Your FSA contributions, as well as the money reimbursed to you, are not subject to:

- Federal income taxes
- Social Security (FICA) taxes
- In most cases, state and local income taxes

Rules vary, and state and local tax laws are subject to frequent change. Please see the discussion "Pre-Tax vs. After-Tax" under "Cost of Coverage" in the "Participation" section of this handbook for a general discussion about the impact of reducing your taxable income by pre-tax contributions.

Dependent Care Account vs. the Income Tax Credit

Based on your income level, you can take a tax credit for your annual Dependent care expenses on your federal income tax return. These expenses are subject to limits. IRS Publication 503 (available at www.IRS.gov can provide you with information that you need to make a decision).

You cannot use the Dependent Care FSA and the tax credit for the same expenses. The approach that offers you the better financial advantage will depend on your income and expenses. You may want to get advice from your professional tax advisor to help you determine which method is better for you.

Flexible Spending Accounts

THE HEALTH CARE FSA

The Health Care FSA offers you an opportunity to pay for eligible expenses with pre-tax salary contributions that you allocate to this account. You may elect to make pre-tax salary contributions up to the limit set forth in your annual enrollment materials.

Eligible Dependents

You can use the Health Care FSA to reimburse your eligible dependents' health-related charges. This includes your spouse, children up to age 26, and any of your dependents eligible under the Plan as a Qualifying Relative or Qualifying Child, even if your dependents are not covered under the medical Benefit Option in this Plan.

Reimbursable and Non-Reimbursable Expenses

The Health Care FSA reimburses you for many, but not all, health care expenses that are tax deductible. In general, you can receive reimbursement for expenses incurred for medical care, which includes amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, provided that they are not reimbursable from any other source and, if they are eligible for a tax deduction under IRS guidelines, you do not take the tax deduction. But, expenses incurred to merely benefit your general health or for personal reasons (such as cosmetic surgery, other than to correct or cure a deformity or correct a congenital abnormality) are not considered expenses for medical care. According to IRS regulations, services are "incurred" when you are provided with the medical care that gives rise to the medical expenses, and not when you are formally billed or charged for, or pay for, the medical care.

The following chart identifies just some examples of eligible and ineligible expenses. Other expenses not listed below may or may not be eligible for reimbursement. To learn more, contact the Plan Administrator.

Reimbursable Expenses	Non-Reimbursable Expenses
• Insurance deductibles and copay for office visits and prescriptions • Charges that exceed reasonable and customary limits • Acupuncture if treating a medical condition • All out-of-pocket non-cosmetic dental expenses not covered by a benefit plan • Hearing care expenses, including those for examinations and hearing aids, if not covered under the medical program or other source • Vision care expenses such as examinations, treatments, eyeglasses and contact lens expenses and laser eye surgery not covered by a benefit plan • Weight loss treatment (with the exception of food costs) associated with a diagnosed disease or ailment such as obesity or hypertension, prescribed by your doctor • Expenses for medical treatments and procedures that are not covered by insurance • Drugs available through prescription only and not covered by the medical program and not used for cosmetic purpose • Over-the-counter medicines and drugs obtained by prescription and purchased to alleviate or treat physical injury or illness (such as antacid medicine, allergy medicine, pain reliever and cold medicines), but not medicines merely beneficial for general health • Insulin purchased without a prescription	Cosmetic treatment or drugs (unless prescribed to treat a congenital defect or accident reconstruction), including: • Hair loss treatments or transplants • Face lifts • Piercings • Teeth whitening • Health club memberships or exercise classes to promote general health • Household help (even if recommended by your doctor because you are unable to do housework) • Individual or group health or dental insurance premiums • Marriage or family counseling • Nutritional supplements, vitamins, herbal supplements or “natural medicines,” which are merely beneficial to general health • Weight loss programs or medications to promote general health • Over-the-counter medicines or drugs (other than insulin) that are not obtained by prescription

THE DEPENDENT CARE FSA

You can use the Dependent Care FSA to pay for some or all of the expenses you incur for the care of a child or adult dependent who resides with you and is incapable of self-care while you work. However, to qualify as an eligible expense, all of the following must be true:

- Care for your dependent(s) must be necessary for you and your spouse, if any, to work, look for work, go to school full-time, or if your spouse, who lives with you, is incapable of self-care as defined by the IRS. In other words, expenses are not eligible if they are for services provided while you are out for the evening socially or on vacation.

- If the care is provided by a day care facility that cares for six or more individuals at the same time, the facility must be licensed and comply with all federal, state and local regulations governing day care centers.

- Your care provider is anyone other than the child’s parent or a person whom you claim as a dependent on your federal income tax return (a relative who provides care must be at least age 19). In addition, you must provide your caregiver’s name, address and Social Security number or taxpayer identification number when you file for reimbursement. You also must provide this information on your federal income tax return, unless your caregiver is a church or other religious organization.

Flexible Spending Accounts

If You Are Married

Under federal law, if you participate in the Dependent Care FSA and your spouse participates in a similar account through his or her own employer, your combined contributions to both accounts in a calendar year may not exceed $5,000 (a lesser limit may apply to highly compensated employees). This limit applies regardless of the number of dependents receiving care. If you and your spouse file separate income tax returns, the most each of you may contribute is $2,500. In addition, your Dependent Care FSA contributions may not exceed the annual income of the lower-paid spouse, if that amount is smaller than the benefit limits indicated above.

In general, you may not participate in the Dependent Care FSA if your spouse does not work outside the home. There are two exceptions: (1) if your spouse does not work outside the home and is physically or mentally unable to care for himself or herself, or (2) if he or she is a full-time student. In either of these cases, for purposes of calculating the contribution limit, the IRS considers your spouse's earned income to be based on the number of dependents in the household. If you participate, it is your responsibility to comply with the federal limits.

Eligible Dependents

An eligible dependent is a child younger than age 13 whom you claim as a dependent on your income tax return. An eligible dependent can also be an older dependent who:

- Depends on you for at least half of his or her support;
- Has the same principal residence as you for more than one-half of the taxable year; and
- Is physically or mentally unable to care for himself or herself.

Your dependent may be a spouse, an elderly parent, or any other relative or dependent, as long as he or she is incapable of self-care and meets all of the above requirements.

Reimbursable and Non-Reimbursable Expenses

Similar to the Health Care FSA, the Dependent Care FSA reimburses you for Dependent care expenses that are tax deductible so that you and your spouse, if any, may work or attend school full time.

The following chart identifies just some examples of eligible and ineligible expenses. Other expenses not listed below may or may not be eligible for reimbursement. To learn more, contact Your Spending Account at the number set forth in the General Information section.

Reimbursable Expenses	Non-Reimbursable Expenses
• Dependent care provided in your home, including care provided by a babysitter or housekeeper. The provider may be a relative (provided he or she is not the child's parent or your child under age 19, your spouse or any other person whom you claim as a dependent on your federal tax return) • Care provided in a neighbor's home or in an approved day care center, provided your dependent regularly spends at least eight hours a day in your home • Before- and after-school programs for children under age 13 • Day camp services for children under age 13, but not overnight camp	• Care provided in 24-hour nursing care facilities • Expenses you claim as an after-tax Dependent care tax credit on your federal income tax return, or expenses paid by any similar reimbursement plan • Expenses to attend kindergarten or beyond • Services provided by a child's parent, your spouse, your child under age 19, or someone you or your spouse claim as a dependent on your tax return • Payments to a housekeeper while you are home from work because of illness • Child or Dependent care provided while: ✓ You are at work and your spouse is doing volunteer work (or vice versa), even if a nominal fee is paid ✓ You and your spouse are doing volunteer work (even if a nominal fee is paid) ✓ You or your spouse is not working (such as weekend or evening babysitting fees) • Transportation expenses to and from the care site (unless the transportation is furnished by the provider) • Expenses for overnight camp • Expenses for food, clothing and entertainment of a qualified dependent, unless charges are incidental and cannot be separated easily from the overall Dependent care cost

APPLYING FOR REIMBURSEMENT

Reimbursement from either FSA is available only after the service for which you are seeking reimbursement is performed and you receive reimbursement from all other sources. As described above, you can pay for eligible health care expenses by using your PayFlex Debit Card or by seeking reimbursement for expenses you paid directly. For eligible Dependent care expenses, you must pay the service provider and then seek reimbursement from your Dependent Care FSA.

Health Care FSA Reimbursements

You may use your PayFlex Debit Card to pay for eligible health care expenses, which means you do not have to submit a claim for reimbursement.

Supporting Documentation

Along with the claim form, submit the appropriate supporting documentation, such as:

- The explanation of benefits (EOB) from the insurance company
- An itemized bill for services not covered by insurance, including the name of the service provider, cost of the service, patient name, description of the services rendered and date of service
- Receipts for any medications and copays

- Copies of any prescriptions if the receipt for the medication does not include an Rx number. This applies to over-the-counter drugs and medicine as well. No reimbursement will be provided for an over-the-counter drug without a prescription or Rx number.

Dependent Care Reimbursements

For Dependent Care FSA claims, only your current account balance is available to reimburse claims. If the Dependent care services exceed your account balance, you receive a partial reimbursement. You receive the unreimbursed portion of the claim as you make additional contributions to your Dependent Care FSA.

Supporting Documentation

When you seek reimbursement, please submit:

- Your provider's bill or itemized receipt;
- Your Dependent care provider's name, address, and Social Security or federal tax identification number; and
- Signed provider certification on the claim form along with Dependent care provider's name, address, and Social Security or federal tax identification number.

Using Your PayFlex Debit Card

You may use your PayFlex Debit Card to pay for eligible health care expenses if you've chosen to contribute to your Health Care FSA. Dependent care expenses aren't eligible for reimbursement through the PayFlex Debit Card program.

If you elect to contribute to a Health Care FSA, you will receive a package containing one PayFlex Debit Card issued in your name, activation instructions, a cardholder agreement, additional disclosures, and information explaining approved use of the card.

The PayFlex Debit Card remains active as long as your Health Care FSA is in good status, you consecutively re-enroll in the Health Care FSA, and you remain actively employed. Your card will be cancelled upon termination of employment—inactive participants may not use the PayFlex Debit Card. By signing and using the card, you certify that:

- You will only use the card for your own eligible health care expenses and those of your eligible dependents under the Health Care FSA.
- Incurred expenses were for health care services or supplies purchased on or after the date your Health Care FSA took effect.
- Your expenses don't include any amounts that are otherwise payable by plans for which you or your dependents are eligible.
- Any expense paid with the card has not been, or will not be, reimbursed by another source.

Because all PayFlex Debit Card transactions must be verified as eligible health care expenses, you may be required to provide the Plan with supporting documentation to validate your expenses. Make sure that you save all of your itemized receipts (indicating the date of service, the name of the service provider, the name of the person receiving service, the name of the product or service, and any amount paid by other coverage).

After the end of any given year, expenses incurred in the prior Plan year (plus the grace period) can be submitted via the manual claim process through March 31st. If you re-enrolled, your balance on the PayFlex Debit Card will be updated to your new election amount on January 1. PayFlex Debit Card transactions that are

not automatically validated will apply toward the new Plan year balance until additional documentation is provided and the claim is approved.

Automatic Validation with Approved Merchants

When you purchase eligible health care items by using your PayFlex Debit Card with approved merchants, your transaction may be validated automatically without having to provide an itemized receipt or supporting documentation. For a complete listing of eligible expenses and approved merchants, visit the web site at www.PayFlexDirect.com. Please note that the listing is subject to change at any time.

Automatic Validation for Other Medical Providers

Your PayFlex Debit Card can also be used for other types of health care transactions without the need for submission of itemized receipts or further review. These transactions include recurring expenses, copayments and specific merchant category code. Below is a brief explanation of each type of transaction.

Recurring Transactions

If you purchase an eligible health care item or service using your PayFlex Debit Card, that same item or service will be validated automatically the next time you purchase it with your PayFlex Debit Card (at the same provider and for the same dollar amount). Your PayFlex Debit Card will be programmed to recognize your plan's copayment amounts without any additional validation being required (for example, a $25 copayment at a physician's office).

Supporting Documentation

Manual claim submission and supporting documentation are sometimes required for the purchase of any prescription drug or health care service or item that isn't validated automatically. These types of purchases are conditionally reimbursed, pending validation of the expenses. You will be sent a letter or email informing you that itemized receipts or other documentation are required to validate the PayFlex Debit Card transaction. Expenses for which you don't provide adequate documentation are considered ineligible and treated as overpayments. See the Overpayment Process section for more information.

Overpayment Process

If you purchase products or services with your PayFlex Debit Card that are ineligible for reimbursement through your Health Care FSA, you will receive notification that your transaction has been deemed an overpayment.

Once an overpayment has been identified, the following actions will be taken immediately:

- Your PayFlex Debit Card will be suspended and will remain suspended.
- If you provide the required validation documentation, the overpayment(s) will be cancelled and any claim(s) applied to offset the overpayment will be applied to the appropriate Plan year.
- Future paper claims will be processed, and eligible amounts will be applied to the outstanding overpayment. Payment will not be made on any paper claim until the overpayment has been fully repaid.
- You will be notified that you must refund the overpayment by mailing a check to PayFlex Debit Card address indicated on the notification.
- You may resolve an overpayment on your account in one of the following ways. You will be given the option to:
    - Resubmit your claim with additional information;

- Submit a new claim; or
- Repay your overpayment by mailing a check to the appropriate address.

The overpayment will remain active on the account until all amounts are recovered. If the overpayment amount isn't recovered through the options above, the Plan Administrator or UCOR will determine whether further action should be taken.

When Not to Use Your PayFlex Debit Card —Coinsurance

You may use your PayFlex Debit Card to make office copayments at the time of service. However, if you enrolled in a Benefit Option that has coinsurance (rather than a fixed dollar amount for an office copay) and you visit your doctor, you may wish to wait until after your doctor submits a claim to your health plan to pay for any coinsurance using your PayFlex Debit Card. This is because doctors often have negotiated reduced rates that are adjusted after you receive service, so using your PayFlex Debit Card at the time of service for any payment other than an office copayment may result in an overpayment. Once your health plan pays its portion of the claim, your doctor will bill you for your portion that is not an office copayment that was required at the time of service. At that time, you may use your PayFlex Debit Card to pay your portion of the bill. Remember to save your receipt in case it is requested.

Also, do not use the PayFlex Debit Card to pay bills or claims incurred in the prior plan year during the current plan year or grace period balance. Any PayFlex Debit Card charges can only be incurred within the current plan year, however once approved the amount can be applied against any remaining prior year's balance during the extension period.

Finally, your PayFlex Debit Card will be deactivated if you are on a leave of absence. You can still file claims manually by sending in any paper claim forms.

GENERAL INFORMATION

General Information

PLAN ADMINISTRATION

The Plan Administrator has the sole and complete discretionary authority to determine eligibility for UCOR Plan benefits and to construe the terms of the UCOR Plan, including the making of factual determinations. The Plan Administrator shall have the discretionary authority to grant or deny benefits under the UCOR Plan. Benefits under the UCOR 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 UCOR 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 Plan Administrator may delegate certain of its duties to other persons and may seek such expert advice as the Plan Administrator deems reasonably necessary with respect to the UCOR Plan. The 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 Plan Administrator may adopt uniform rules for the administration of the UCOR Plan from time to time, as it deems necessary or appropriate.

Amendment and Termination

UCOR, as the Plan Sponsor, and the UCOR Amendment Committee, as the Plan Administrator, reserve the sole discretionary right to modify, amend or terminate the UCOR Plan, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by the UCOR 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 UCOR 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 UCOR Plan is modified, amended or terminated, you will be notified of the effect of such change to your UCOR 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 UCOR Plan described in this SPD.

Representations Contrary to the Plan

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

No Assignment

To the extent permitted by law, and except as specified under the terms of the UCOR 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 UCOR Plan may be subject to a Qualified Medical Child Support Order (QMCSO).

General Information

Recovery of Benefit Payments Made by Mistake

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

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 UCOR Plan does not assure you of continued employment with UCOR or rights to benefits except as specified under the terms of the UCOR Plan. Nothing in the UCOR 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 UCOR Plan described in this SPD to be void, unlawful or unenforceable under any applicable statute or other controlling law, the remainder of the UCOR Plan shall continue in full force and effect.

Plan Funding

Benefits offered under the UCOR Plan are provided on either a self-insured basis 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 UCOR 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.

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 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.

General Information

Interpretive Authority

If the UCOR Plan document does not clearly dictate whether an expense is eligible under the UCOR 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 UCOR Plan document, the Plan Administrator has discretionary authority to interpret, construe and apply the terms of the 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 UCOR Plan.

Statement of ERISA Rights

As a UCOR 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 UCOR Plan documents, including insurance contracts, and copies of all documents filed by the 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 UCOR 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 Plan Administrator may make a reasonable charge for the copies.

- Receive summaries of the Plan's annual financial reports. These summaries are prepared and distributed to UCOR Plan participants each year. The 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 Plan regarding the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

No one, including UCOR 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 UCOR Plan documents or the latest annual report from the UCOR 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.

General Information

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 UCOR 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 UCOR Plan fiduciaries misuse the UCOR 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 UCOR 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 ("UCOR") P.O. Box 4699 MS 7020, K-1007 OAK RIDGE, TN 37831 865-576-9206 Employer Identification Number: 45-2178216
Plan Administrator	UCOR Benefits and Investments Committee P.O. Box 4699 MS 7020 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 Corporate Systems 800 South Gay Street, Suite 2021 Knoxville, Tennessee 37929 Service of legal process may also be made on the Plan Administrator.
Plan Name **Plan Number** **Plan Year**	URS | CH2M OAK RIDGE LLC Health and Welfare Benefit Plan Plan No. 501 January 1 – December 31
Plan Type	This UCOR Plan is an employee welfare benefit plan offering benefit coverages to eligible employees of UCOR.
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 Plan Administrator or its delegate.
Named Fiduciary (for Benefit Claims)	The 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 UCOR Plan and is responsible, except to the extent provided hereof, for administering the 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
Flexible Spending Accounts	Self-Insured by UCOR	PayFlex 1-888-678-8242
COBRA Administrator	Not Applicable	Discovery Benefits 1-866-451-3399
Employee Assistance Program	Fully insured insurance contract with Aetna	Aetna Resources for Living™ 1-888-238-6232 www.resourcesforliving.com
AD&D Insurance	Fully insured insurance contract with Securian Life Insurance	Securian 1-888-658-0193
Business Travel Accident Insurance	Fully insured insurance contract with CIGNA Life Insurance Company of North America	Plan Administrator 1-865-576-9206