NORDSTROM, INC.
INJURY BENEFIT PLAN FOR TEXAS EMPLOYEES

(AMENDED AND RESTATED EFFECTIVE APRIL 1, 2016)

SUMMARY PLAN DESCRIPTION

NOTICE TO ENGLISH SPEAKING EMPLOYEES: This booklet contains a summary in English of your plan rights and benefits under the Nordstrom, Inc. Injury Benefit Plan For Texas Employees. If you have difficulty understanding any part of this booklet, contact Risk Management at P.O. Box 25799, Santa Ana, California 92799, 888.916.5700. Office hours are from 8:00 a.m. to 5:00 p.m., Monday through Friday.

AVISO A LOS EMPLEADOS QUE NO HABLAN INGLES: Este folleto contiene un resumen en inglés de sus derechos y beneficios del plan de Nordstrom, Inc. Injury Benefit Plan For Texas Employees. Si tiene dificultad en entender cualquier parte de este folleto comuníquese con Risk Management en el P.O. Box 25799, Santa Ana, California 92799, 888.916.5700. El horario de oficina es de 8:00 a.m. a 5:00 p.m., de lunes a viernes.

Dear Nordstrom Employee,

Although safety is a top priority at Nordstrom, Inc., we all understand that work-related injuries may occur. When they do, you deserve prompt, quality medical treatment and salary continuation if you need to recover at home. In 1996, we developed a program called the Nordstrom, Inc. Injury Benefit Plan for Texas Employees with those goals in mind. This Plan is updated from time to time – most recently effective April 1, 2016.

This Summary Plan Description (SPD) summarizes the key provisions of the benefit plan and alerts you to actions that could limit the benefits you are eligible to receive. This SPD has been designed to help you find the answers you are looking for and has been written as much as possible in simple straightforward language that is easy to understand.

As a reminder, you do not pay for any coverage under the Plan. The coverage provided is funded entirely by Nordstrom. For more important information about the Plan be sure to read the Summary Plan Description (SPD).

We sincerely hope you never need to make a claim for such benefits. However, if you are injured at work, you can rest assured that this valuable benefit plan is available to protect you and your family.

If you have any questions, please contact the Nordstrom Risk Management office at 888.916.5700 to speak with a Plan representative.

TABLE OF CONTENTS

Page

PROGRAM HIGHLIGHTS 1

Why did the Company start this Plan? 1
Who is covered by the Plan? 1
How does the Plan affect me? 1
What are some advantages of the Plan? 1
Is there a waiting period before my wage replacement benefits will begin? 1
When do I need to report my injury? 1
What if my benefit claim is denied for some reason? 2
Does this Plan directly affect my health insurance or other benefits? 2
When does this updated Plan take effect? 2

PLAN BENEFITS 3

CASE STUDY 4

How does the Plan work? 4

REPORTING AN INJURY 5

What should I do if I am injured on the job? 5

PROGRAM DETAIL 6

INTRODUCTION 6

NOTICE TO EMPLOYEES CONCERNING WORKERS' Compensation in Texas 6

ELIGIBILITY 7

HOW THE PLAN WORKS 7

Medical Determinations and Treatment 7
Procedure in Event of Injury 8
Funding 8

COVERED AND NON-COVERED INJURIES 9

Covered Injuries 9
Types of Non-Covered Injuries 9
Non-Covered Injury Circumstances 10

WAGE REPLACEMENT BENEFITS 12

Eligibility 12
When Wage Replacement Benefits Begin 12
When Wage Replacement Benefits Cease 12

DEATH BENEFITS 13

DISMEMBERMENT BENEFITS 13

Schedule of Losses 14
Loss of: 14
Benefit Amount: 14

MEDICAL BENEFITS 15
First and Continuing Treatment 15
Approved Medical Provider and Pre-Authorization Requirements 15
Covered Medical Services and Supplies 16
Medical Services and Supplies Requiring Written Authorization 16
Non-Covered Medical Services and Supplies 17
Treatment Prior to Denial 17
Medical Provider Referrals 18
No Interference with Patient-Provider Relationship 18
Independent Medical Evaluation or Medical Records Review 18
Your Right to a Second Medical Opinion 18
When Medical Benefits Cease 19
REQUESTING BENEFITS 19
Notice of Injury 19
Providing Required Information 19
Good Cause 19
CONTINUING BENEFITS 20
DETAILED CLAIM PROCEDURES 20
Filing a Claim for Benefits 20
Timing of Notice of Initial Benefit Determination 21
Manner and Content of Adverse Benefit Determinations 24
Filing an Appeal 25
Appeal Committee Review 25
Timing of Notice of Benefit Determination on Review 26
Manner and Content of Benefit Determination on Review 26
Standards for Culturally and Linguistically Appropriate Notices 27
Extension of Timeframes Allowed by Law or Agreement 27
Exhaustion of Administrative Remedies 27
VOLUNTARY FINAL COMPROMISE AND SETTLEMENT 28
OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFIT 28
Offset of Benefits 28
Coordination of Benefits 28
Subrogation and Reimbursement Rights 29
Notice of Legal Proceedings 30
Assignment of Rights 31
Right to Receive and Release Necessary Information 31
APPLICABLE LAW 31
AMENDMENT OR TERMINATION OF PLAN 32
DEFINITIONS 32
Adverse Benefit Determination 32
Appeals Committee 32
Approved Facility 32
Approved Medical Provider 32
Approved Physician 33

Beneficiary....33
Claims Administrator....33
Course and Scope of Employment....34
Disabled or Disability....34
Emergency Care....35
Good Cause....35
Gross Misconduct....35
Making the Safey Commitment....35
Maximum Benefit Limit....35
Maximum Rehabilitative Capacity....35
Medically Necessary....36
Plan....36
Plan Administrator....36
Post-Service Claim....36
Preexisting Condition....36
Pre-Injury Pay....36
Pre-Service Claim....37
Representative....37
Transitional Duty....37
Traumatic Event....37
Urgent Care Claim....37
Usual and Customary....38

GENERAL INFORMATION....38

Type of Plan and Administration....38
Name and Address of Plan Sponsor....38
Name and Address of Plan Administrator....38
Name and Address of Person Designated as Agent for Service of Legal Process....39
Employer and Plan Identification Numbers....39
Plan Year....39

ERISA RIGHTS STATEMENT....39

Receive Information About Your Plan and Benefits....39
Continue Group Health Plan Coverage....39
Prudent Actions by Plan Fiduciaries....39
Enforce Your Rights....40
Assistance with Your Questions....40

APPENDIX A: COBRA CONTINUATION COVERAGE....41

PROGRAM HIGHLIGHTS

Why did the Company start this Plan?

Nordstrom created the Nordstrom, Inc. Injury Benefit Plan For Texas Employees (the "Plan") with a goal of providing more efficient and quality care than the current workers' compensation system. Taking care of our employees, particularly when they have been injured at work, is extremely important to us. Our priority is to ensure our employees can quickly and efficiently get the quality care they need and the benefits they deserve.

Who is covered by the Plan?

All Texas employees of Nordstrom, Inc. and its parents, subsidiaries and affiliated employers will be covered by this program.

How does the Plan affect me?

If you are injured on the job, Nordstrom can provide you with many benefits under the Plan, including paying for your covered medical care and making sure you receive a paycheck if you need to stay at home to recover. **Nordstrom pays the entire cost of the Plan.**

What are some advantages of the Plan?

- No waiting period. You are eligible for wage replacement benefits on the first full day that an approved physician takes you off work.
- Access to medical providers that (in some cases) won't accept patients covered by workers' compensation.
- Prompt response to any of your questions and concerns.

Is there a waiting period before my wage replacement benefits will begin?

No. Instead of the seven-day waiting period that is required by Texas Workers' Compensation, the Plan starts replacing your wages with a paycheck from the first full day that you miss work.

When do I need to report my injury?

All accidents and injuries need to be reported immediately – no matter how minor the accident or injury appears to be. You will not get in any trouble for reporting! In fact, your injury might otherwise get worse and we want you to receive the medical care you need.

- For an injury due to an accident, you must report your injury no later than thirty (30) calendar days from the date of the accident.
- For an injury due to an occupational disease or cumulative trauma, you must report your injury no later than thirty (30) calendar days from:
  - the date that you are medically diagnosed with an occupational disease or cumulative trauma, or
  - you otherwise should have known of your occupational disease or cumulative trauma.

Who do I report my injury to?

You should report your injury to your Department Manager, Human Resources Department, or the Manager-in-Charge.

How is medical care handled under the Plan?

To receive Plan benefits, you may only use physicians, hospitals and clinics that have been approved by the Claims Administrator ("approved medical providers").

- These approved medical providers have been chosen for their ability to provide occupational injury medical services.
- If you are not satisfied with the decision or diagnosis by an approved physician, you can get a second medical opinion from another physician (as described later in this booklet).

You must also receive your first medical treatment from an approved medical provider within 14 days after the date you report your accident and/or injury.

What if my benefit claim is denied for some reason?

You have the opportunity to file an appeal with a separate Appeals Committee. On appeal, the Appeals Committee will conduct an independent review of the claim and you can submit additional information supporting payment of the claim.

Does this Plan directly affect my health insurance or other benefits?

No. This Plan is a separate program from your health insurance and other benefits and applies only when injuries happen on the job.

When does this updated Plan take effect?

It is effective for all work-related injuries involving Texas employees that occur on or after April 1, 2016.

PLAN BENEFITS

Medical Benefits	
Pays for care from approved medical providers for a work-related injury	• **100%** of covered charges. • Pays up to **156 weeks**.

Wage Replacement Benefits	
Pays you weekly income if you miss work for a work-related injury	• Starting on the first full day of disability • Pays 100% of your "lost wages" for the first six months; pays 90% thereafter. • Pays up to 156 weeks.

Death Benefits	
Provides payment to your beneficiaries if you have a work-related death	**$200,000** (paid 20% down and remainder over 35 months)

Burial Benefit	
Provides reimbursement for burial expenses	Up to **$10,000**

Dismemberment Benefits	
Provides payment for loss (or loss of use) of a covered body part	Up to **$200,000,** based upon the severity of the work-related injury (paid 20% down and remainder over 35 months)

Maximum Benefit Limit	
Maximum amount for all benefits combined for a work-related injury	• **$1,000,000** per employee • **$1,000,000** per occurrence

CASE STUDY

How does the Plan work?

Take a look at the example below to see how the Plan's benefits might work if you have an injury.

Pat, who works in Women's Shoes, suffers a back injury. Pat, who earns $500 a week, is not able to return to work until three weeks after the accident. Pat's total covered medical charges following the accident are $3,000.

The Bottom Line

In this example, Pat would be eligible to receive **$4,500** under the Plan.

Pat would receive:

- $3,000 in Medical Benefits (100% of all covered medical charges)
- $1,500 in Wage Replacement Benefits (100% of lost wages for the three weeks of disability)

Of course, Pat's case is just an example and might not be like your situation at all if you're injured on the job. You may be entitled to receive more or less benefits than those provided in this example, depending on the severity of your injury and other factors.

This example simply illustrates what a difference having great benefit protection under the Plan can make in certain situations.

REPORTING AN INJURY

What should I do if I am injured on the job?

The Employer has set up procedures to make sure you receive treatment for your injuries in an efficient, quick manner. By following the Plan's rules, your covered medical bills can be paid and your paycheck can continue even if you need to stay at home to recover. More detailed information on these procedures is found later in this booklet.

1. **Report Your Injury Immediately**

   For an injury due to an accident, you must report your injury to your Department Manager, the Human Resources Department or the Manager-in-Charge no later than thirty (30) calendar days from the date of the accident. Don't wait! Your injury might get worse and we want to help you.

2. **Complete an Incident Report**

   You must complete an incident report **by the end of the next calendar day after the date you report the accident and/or injury**. You and the Employer will then work together to investigate your claim.

3. **Use Approved Medical Providers for Medical Treatment**

   In order to receive injury benefits, you must use physicians, hospitals, clinics and other health care providers and facilities that have been approved by the Plan's Claims Administrator. You must also receive your first medical treatment from an approved medical provider within 14 days after the date you report your accident and/or injury.

4. **Follow the Approved Physician's Orders**

   You must follow the approved physician's instructions and keep all scheduled appointments with approved medical providers.

5. **Keep the Employer Informed**

   You must keep the Employer informed about your return to work status, including any changes to your work restrictions. We will look forward to welcoming you back to full duty as soon as the treating physician issues you a medical release to full duty.

PROGRAM DETAIL

INTRODUCTION

Nordstrom, Inc. (the "Company") is committed to providing loss of income protection and helping you pay medical expenses that might otherwise present a financial burden to you if you are injured on the job. To accomplish this, the Company has implemented a benefit program called the Nordstrom, Inc. Injury Benefit Plan For Texas Employees (the "Plan"). **The Plan has been adopted for the benefit of the Texas employees of Nordstrom, Inc. and its parents, subsidiaries and affiliated employers (individually and collectively referred to as the "Employer")**. This booklet has been prepared to help you understand your benefits under the Plan. Please read it carefully.

Except as otherwise provided in this booklet, benefits and other requirements described in this booklet are effective for all covered Injuries occurring on or after April 1, 2016. Certain terms used in this booklet are capitalized and defined in the DEFINITIONS section of this booklet. References in this booklet to "you" or "your" shall mean a person who satisfies the requirements of the ELIGIBILITY section of this booklet.

About Summary Plan Descriptions

Participants and Beneficiaries of the Plan are entitled to be furnished with certain documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including a summary of the significant provisions of the plans. This document is called a Summary Plan Description or SPD.

Your Right to a Printed Copy

A printed copy of this SPD is available to you at any time and at no charge. Contact Risk Management at 888.916.5700. Electronic copies can be found online at mynordstrom.com.

Disclaimer

The Plan is governed by an official plan document. The SPD summarizes key provisions of this Plan. If differences exist between the plan document and the paper or electronic SPD, the plan document will take precedence over the paper or electronic SPD.

The Company intends to continue the benefits described in this SPD indefinitely but reserves the right to amend or terminate the terms of the Plan at any time, for any reason. Oral promises or modifications to the Plan are not binding on the Company. The Plan can be modified only in writing, through the formal amendment procedure described in this SPD booklet.

This document does not create a contract of employment or any rights to continued employment with the Company or any Employer. If you have any questions regarding this Plan, please contact Risk Management at 888.916.5700

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

The following notice is being provided as required by Texas law:

COVERAGE: Nordstrom, Inc. does not have workers' compensation insurance coverage. As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers'

Compensation Act. However, a non-covered (non-subscribing) employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits for a work-related injury or occupational disease. In addition, you may have rights under the common law of Texas should you have an on the job injury or occupational disease. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

SAFETY VIOLATIONS HOTLINE: The Division has established a 24-hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 800.452.9595.

This notice also applies to all Employers participating in the Plan.

Your Injury Benefit Plan: The Employer **DOES PROVIDE** to all Texas employees, without cost, the Plan described in this booklet.

Our Safety Program: Our success largely depends upon you following all of our safety rules and procedures and **immediately notifying your supervisor first** of any unsafe working condition, safety violation or on-the-job injury, no matter how minor. As mentioned above, you will not be suspended, terminated, or discriminated against because you in good faith report an unsafe working condition, on-the-job injury or potential occupational health or safety violation.

ELIGIBILITY

You automatically become a participant in the Plan if you are an employee of the Employer and your employment with the Employer is principally located within the State of Texas. You must be a person who is employed in the regular business of, and receive your pay by means of a salary, wage or commission directly from, the Employer and for whom the Employer files a Form W-2 with the Internal Revenue Service.

This Plan does not cover an independent contractor or other third-party agent.

HOW THE PLAN WORKS

Medical Determinations and Treatment

In order to receive any benefits under this Plan, all medical care must be **pre-approved by the Claims Administrator** and furnished by or under the direction of **Approved Medical Providers acting within the scope of their license** (unless provided in connection with Emergency Care as described below).

Any list of Approved Physicians and Approved Facilities can be furnished to you, without charge, as a separate document. The Claims Administrator reserves the right to add to, delete from, or otherwise amend any list of Approved Medical Providers at any time. **No Approved Medical Provider is an agent of the Employer. Although benefits under this Plan are conditioned on your use of only Approved Medical Providers, you remain entitled to seek any medical care you deem appropriate from any health care provider of your choice at your own expense. In addition, the Plan is not intended to affect your relationship with your health care providers. The actual medical treatment or rehabilitation of any Injury remains the sole prerogative and responsibility of you and your attending Approved Physician and other health care providers based on their independent judgment for the provision of health care.**

For purposes of this Plan, all determinations relating to your physical condition and the payment of benefits (for example, inability to return to work) must be made by an Approved Physician. You must follow fully and completely the advice of, and the course of medical treatment prescribed by, the treating Approved Physician, and must keep all scheduled appointments to fulfill the prescribed medical treatment plan. The Claims Administrator will have the right to require you to be examined or reexamined by an Approved Physician as often as they determine to be reasonably necessary or appropriate while you are receiving or claiming benefits under the Plan.

Procedure in Event of Injury

- You must notify your Department Manager, the Human Resources Department or the Manager-in-Charge immediately after an Accident or Injury at work, no matter how minor the Accident or Injury appears to be.
  - For an Injury due to an Accident, notice must be provided no later than 30 calendar days from the date of the Accident.
  - For an Injury due to Occupational Disease or Cumulative Trauma, notice must be provided within 30 calendar days after (1) you are medically diagnosed with an Occupational Disease or Cumulative Trauma or (2) you should have known of the Occupational Disease or Cumulative Trauma.
  - For purposes of an Injury that involves an Accident, the date of the Injury shall be the date of the Accident resulting in the Injury. For purposes of an Injury that involves an Occupational Disease or Cumulative Trauma, the date of the Injury shall be the earlier of (1) the date that the damage, harm or symptoms of the Occupational Disease or Cumulative Trauma were first known (or should have been known) to you, or (2) the date that an Approved Physician medically diagnosed you with an Occupational Disease or Cumulative Trauma.
- You must submit a written incident report to your Department Manager, the Human Resources Department or the Manager-in-Charge by the end of the next calendar day after the date you report the Accident and/or Injury.
- **You must receive medical care from Approved Medical Providers.** The Plan does provide an exception for true Emergency Care as described in the MEDICAL BENEFITS section of this booklet.
- You must receive your first medical treatment from an Approved Medical Provider within 14 days after the date you report your Accident and/or Injury. If necessary, the Claims Administrator will assist you in arranging for appropriate treatment.
- You must obtain pre-approval for all medical care from the Plan's Claims Administrator. You do not have the right to select and have the Plan pay for your choice of a primary care provider or provider of specialty medical care, even if such provider is an Approved Physician or Approved Facility.
- You must also follow the additional procedures described below in the REQUESTING BENEFITS section and comply with the requirements of the CONTINUING BENEFITS section of this booklet.

Funding

The Employer currently pays the entire cost to provide your coverage under this Plan and pays Plan benefits solely out of the general assets of the Employer. The Employer has the right, but no obligation, to obtain insurance contracts to provide funds to the Employer that can be used by the Employer to pay all or any portion of a benefit under the Plan. However, no benefits under the Plan are guaranteed under any contract or policy of insurance and the Employer will be solely responsible for the payment of claims under this Plan. If the Employer has purchased an insurance policy, then no such insurance policy proceeds shall be considered "plan

assets" for purposes of ERISA. Policy proceeds shall constitute a part of the general assets of the Employer. Any such insurance policy shall be owned by, and all amounts under the policy shall be payable to the Employer, and you shall not have any interest in, or right to, any amounts payable under the policy.

COVERED AND NON-COVERED INJURIES

Covered Injuries

The Plan pays benefits only on account of an **"Injury."** An "Injury" means damage or harm to the physical structure of the body (or mental or emotional state with respect to a Traumatic Event) resulting from either an Accident, Occupational Disease or Cumulative Trauma.

- An **"Accident"** is an event involving factors external to you that:
  - was unplanned, and unexpected;
  - occurred at a specifically identifiable time and place; and
  - occurred by chance or from unknown causes;

  The term "Accident" shall include a Traumatic Event (for example, a robbery) or a known Occupational Disease exposure (for example, a needlestick puncture).
- An **"Occupational Disease"** is a condition that is (1) marked by a pronounced deviation from your normal healthy state arising out of your assigned duties in your Course and Scope of Employment and (2) causes damage or harm to the physical structure of the body.
  - Occupational Disease includes other diseases or infections that naturally result from the work-related disease.
  - Occupational Disease does not include ordinary diseases of life to which the general public is exposed outside of your assigned duties in your Course and Scope of Employment.
- A **"Cumulative Trauma"** is damage to the physical structure of your body occurring as a result of rapid, repetitious, physically traumatic activities that occur in the Course and Scope of Employment.
  - The term "Cumulative Trauma" does not mean fatigue, soreness or general aches and pain that may have been caused, aggravated, exacerbated or accelerated by your Course and Scope of Employment.

  No benefits will be payable with respect to Cumulative Trauma unless you have completed at least 180 days of continuous, active employment with the Employer and have been regularly engaged in the Course and Scope of Employment with the Employer involving rapid, repetitious, physically traumatic activities.

Types of Non-Covered Injuries

The term "Injury," as used in this booklet, does <u>not</u> include:

- Any strain, degeneration, damage or harm to, or disease or condition of, the eye or musculoskeletal structure, or other body part resulting from:
  - poor or inappropriate posture;
  - the natural results of aging;
  - osteoarthritis, arthritis, or degenerative process; or
  - other circumstances prescribed by the Claims Administrator which do not directly and solely result from your Course and Scope of Employment;

- Diagnostic labels which imply generalized musculoskeletal aches and pains in the absence of any demonstrable primary pathophysiology, such as Fibrositis, Fibromyalgia, Myofascial Pain Syndrome, Myositis, or Chronic Fatigue Syndrome;
- Except to the limited extent provided with respect to a Traumatic Event, any mental injury, emotional distress, mental trauma or similar injury to your mental or emotional state, including, without limitation:
  - any physical manifestations resulting from such mental or emotional state; and
  - any mental or emotional damage or harm that arises primarily from a personnel action, including, but not limited to, a transfer, promotion, demotion or termination of employment or other disciplinary action;
- Ptomaine or bacterial infection, except pyogenic infection which occurs with and as a result of an accidental cut or wound;
- Damage or harm resulting from airborne contaminants not commonly found in the Employer's normal working environment, including, but not limited to, pollen, fungi, and mold;
- Damage or harm resulting from job stress;
- Any heart attack, stroke, or aneurysm (an "attack"), unless:
  - the attack can be identified as:
    - occurring at a definite time and place; and
    - caused by a specific event related to, and occurring in, the Course and Scope of Employment;
  - the preponderance of the medical evidence regarding the attack indicates that your work rather than the natural progression of a preexisting heart condition or disease was a substantial contributing factor of the attack; and
  - the attack was not triggered solely by emotional or mental stress factors, unless it was precipitated by a sudden work-related stimulus;
- Hernia, unless inguinal and/or umbilical hernia that:
  - appeared suddenly and immediately following the Injury;
  - did not exist in any degree prior to the Injury; and
  - was accompanied by pain; or
- Any Preexisting Condition, except to the limited extent (if any) that an Approved Physician clearly confirms an identifiable and significant aggravation (incurred in the Course and Scope of Employment) of a Preexisting Condition; provided, however, that:
  - coverage for such aggravation will be provided only if and to the extent that the Approved Physician –
    - confirms that the Preexisting Condition has been previously repaired or rehabilitated; and
    - prescribes services or supplies that are medically necessary to treat such aggravation and likely to return you to pre-Injury status; and
  - no coverage will be provided if the Preexisting Condition was a major contributing cause of the Injury.

Non-Covered Injury Circumstances

Furthermore, no benefits will be payable under the Plan if:

- the Injury occurred while you were in a state of intoxication or had otherwise lost the normal use of your mental or physical faculties as a result of the use of a drug or alcohol. Such intoxication or loss of faculties

may be established on the basis of the facts and circumstances of the Injury, the testimony of witnesses, admissions or statements from you, or on such other basis as the Claims Administrator may determine;

- the Injury occurred under circumstances where your employment did not place you at a greater risk of Injury than you would have been exposed to as a member of the general public;
- the Injury is treatable by medical care that is reasonable and of a form that an ordinary prudent person in the same or similar circumstances would undergo, and you have not availed yourself of such treatment;
- the Injury was caused by your willful intention or attempt to injure yourself or another person, whether you were sane or insane;
- the Injury occurred while you were employed in violation of any law;
- your horseplay, fighting, or similar inappropriate behavior was a proximate cause of the Injury;
- the Injury arose out of an act of a third person intended to injure you because of personal reasons and not directed at you as an employee or because of your employment;
- the Injury arose out of your participation in an off-duty recreational, social or athletic activity not constituting part of your work-related duties, except where these activities are expressly required in writing by the Employer (more than an invitation or request to participate or attend);
- the Injury arose out of an act of God, unless your employment exposes you to a greater risk of Injury from an act of God than ordinarily applies to the general public;
- the alleged Injury is feigned or an attempt to defraud the Employer;
- the Injury arose out of your participation in:
  - a riot or act of civil disturbance;
  - a war, declared or undeclared;
  - any act of war or terrorism;
  - any illegal act;
  - a felony or an assault, except an assault committed in defense of the Employer's business or property; or
  - service in the military of any country or any civilian non-combatant unit serving with such forces;
- any damage or harm arising out of the use of or caused by:
  - asbestos, asbestos fibers or asbestos products; or
  - the hazardous properties of nuclear material or biological contaminants;
- the Injury arose out of your participation in the commission, or attempted commission, of any crime; or
- the Injury occurred while you were traveling or flying in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation if you are:
  - flying in any aircraft that is rocket propelled;
  - flying in any aircraft used for aerobatics, racing or an endurance test, crop dusting, seeding, fertilizing, or spraying, fighting a fire, any exploration or pipe or power line patrol, the pursuit of animals or birds, aerial photography, banner towing or skywriting or any test or experimental usage;
  - flying when a special permit or waiver from the proper authority has to be issued;
  - riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
  - performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
  - riding as a passenger in an aircraft owned, leased, or operated by the Employer;

WAGE REPLACEMENT BENEFITS

Eligibility

An Approved Physician must make the determination regarding whether a Participant is Totally Disabled or Partially Disabled, except to the extent that such determination is made in conjunction with Emergency Care as determined by the Claims Administrator.

When Wage Replacement Benefits Begin

- **Total Disability.** From the first full day that you become Totally Disabled due to a covered Injury, the Plan shall pay Wage Replacement Benefits equal to 100% of your Pre-Injury Pay for the first six months of Total Disability, and 90% of your Pre-Injury Pay thereafter.
- **Partial Disability.** From the first full day you become Partially Disabled, the Plan shall pay Wage Replacement Benefits equal to 100% of your Pre-Injury Pay for the first six months of Total Disability, and 90% thereafter, of the portion of your Pre-Injury Pay that you are unable to earn (due to the Approved Physician's restrictions) while working Transitional Duty.
  - If you have a Partial Disability and are released to Transitional Duty, but (i) the Employer has no Transitional Duty position available, and (ii) an Approved Physician has not assigned permanent restrictions and released you to any other gainful employment, then you will be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified above under "Total Disability."
  - If you have a Partial Disability and have made a good faith effort to comply with the treating Approved Physician's instructions and carry out your responsibilities in the Transitional Duty position, but you are either:
    - again determined by an Approved Physician to be Totally Disabled, or
    - the Transitional Duty position ceases to be available (for example, the position reaches its maximum duration) and an Approved Physician has not assigned permanent restrictions and released you to any other gainful employment;

    then you will be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified above under "Total Disability."

  The Employer's ability to provide a Transitional Duty position while you are under work restrictions determined by the Approved Physician does not imply or create a permanent Transitional Duty position for the purposes of the American with Disabilities Act ("ADA").
- **Payment Terms.** Wage Replacement Benefits are calculated on a weekly basis, and paid on regular paydays. Payments for portions of a week shall be prorated. Only your normal, scheduled workdays shall be considered in calculating benefits (based upon your employment status as of the date of Injury). Wage Replacement Benefit payments shall be reduced as described in the "Offset of Benefits" section of this booklet.

When Wage Replacement Benefits Cease

Wage Replacement Benefits will continue until the earliest of:

- the expiration of 156 weeks from the date of the Injury. This 156-week maximum period for Wage Replacement Benefits is calculated continuously from the date of the Injury, regardless of whether or not

you qualify as Disabled at all times during such period or receive Wage Replacement Benefits continuously throughout such period;

- the date you are determined by an Approved Physician to no longer be Disabled, without regard to whether you return to regular or Transitional Duty on that date;
- the date that the Maximum Benefit Limit is met;
- termination of all your employment with the Employer; provided, however, that this paragraph will not apply if termination of employment is solely due to:
  - application of a duration limit in the Employer's leave of absence policy, or
  - elimination of your employment position;
- the date you are placed in jail, are deported or detained by or at the request of any government agency or foreign government, have left the local area for an extended period of time, or are similarly unavailable for work; provided, however, that this paragraph shall operate to cease Wage Replacement Benefits only for such period of time that you are unavailable for work; or
- the date you reach Maximum Rehabilitative Capacity or permanent restrictions have been assigned; or
- the date you fail to comply with the requirements specified under the CONTINUING BENEFITS section below.

DEATH BENEFITS

If you die as the direct and sole result of, and within 365 days of, an Injury, then the Plan will pay your Beneficiary a Death Benefit equal to $200,000; provided, however that this benefit amount shall be reduced to the extent necessary to avoid exceeding the Plan's Maximum Benefit Limit.

The Death Benefit will be paid to your Beneficiary as follows: (1) 20% will be paid in a lump sum cash payment as soon as administratively possible following your death; and (2) the remainder will be paid in 35 equal monthly installments (without interest) commencing on the first day of the month following the initial lump sum payment.

- Death Benefits will be in addition to Dismemberment Benefits, Wage Replacement Benefits, and Medical Benefits payable with respect to any one Injury; provided, however, that no interest in future Dismemberment Benefits survives after your death if your Beneficiary then becomes entitled to Death Benefits under this Plan.
- In addition to the Death Benefits set forth above, the Plan shall reimburse reasonable burial expenses to any person who incurs liability therefore, up to $10,000.

DISMEMBERMENT BENEFITS

If you suffer a loss described in the Schedule of Losses below as the direct and sole result of, and within 365 days of, an Injury, then the Plan will pay you an amount equal to the applicable percentage from the schedule below times $200,000; provided, however that this benefit amount shall be reduced to the extent necessary to avoid exceeding the Plan's Maximum Benefit Limit.

The Dismemberment Benefit will be paid as follows: (1) 20% will be paid in a lump sum cash payment as soon as administratively possible following the date of loss; and (2) the remainder will be paid in 35 equal monthly installments (without interest) commencing on the first day of the month following the initial lump sum payment.

Schedule of Losses

Loss of:	Benefit Amount:
Both Hands	100%
Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Speech and Hearing	100%
One Hand	50%
One Foot	50%
Sight of One Eye	50%
Speech	50%
Hearing	50%
Finger or Toe (two joints)	10%
Finger or Toe (one joint)	5%

- If you suffer more than one Injury described above from any one Accident, related series of Accidents, or Occupational Disease exposure or Cumulative Trauma exposure only one of the applicable Dismemberment Benefits listed above, the largest single amount, will be payable with respect to such Accident or exposure.
- Total and permanent loss of use of a member of the body is the same as loss of such member. Prior to payment of the benefit, loss of use must be certified following the care of an Approved Physician for 12 straight months from the date the loss of use began. At the end of this time it must be medically determined by an Approved Physician that the loss of use is total and not reversible.
- Loss of Hand or Foot means the complete and permanent severance through or above the wrist or ankle joint. Loss of Sight means legally blind. Such loss correctable by surgery or lenses will not result in payment of a Dismemberment Benefit. Loss of Speech means the total and permanent loss of speech. Loss of Hearing means the total and permanent loss of hearing in both ears.
- The above-described loss of "Finger or Toe (two joints)" must be at or above the joint at the proximal end of the middle phalanx of the finger or toe; except that for the thumb or great toe, such loss must be at or above the metacarpophalangeal joint. The above-described loss of "Finger or Toe (one joint)" must be at or above the joint at the distal end of the middle phalanx of the finger or toe; except that for the thumb or great toe, such loss must be at or above the joint at the distal end of the proximal phalanx.
- If a loss of one hand is associated with the dominant hand the above calculated benefit for Loss of One Hand shall be increased by an additional 10%.
- Dismemberment Benefits shall be in addition to Wage Replacement Benefits and Medical Benefits; provided, however, that payment of Dismemberment Benefits will cease in the event of your death, which results in the payment of Death Benefits.

MEDICAL BENEFITS

Subject to the medical management and other provisions of this Plan, medical services and supplies that are approved by the Claims Administrator (referred to below as "Covered Charges") are covered at 100%, with no co-pays, deductibles or other out-of-pocket expense to you, provided that all applicable Plan requirements are satisfied. The service or supply must be Medically Necessary, based on the nature of the Injury, as and when provided, and (1) cure or relieve the effects naturally resulting from the Injury; (2) promote recovery from the Injury; or (3) otherwise enhance your ability to return to or retain employment. Such services and supplies are also subject to Usual and Customary charge requirements and other medical management provisions of the Plan. Coverage also requires satisfaction of the following requirements:

First and Continuing Treatment

- The first Covered Charge must be received from an Approved Medical Provider and incurred within 14 days following the date you report the Accident and/or Injury (unless the Claims Administrator determines that Good Cause exists); and
- No further amount shall be considered a Covered Charge if you do not receive medical treatment from an Approved Medical Provider for a period of more than 60 days (unless the Claims Administrator determines that Good Cause exists).
  - This section shall not apply if the Claims Administrator has approved scheduled medical treatment with an Approved Medical Provider during the applicable 60-day period, even if such medical treatment occurs beyond the 60-day period (for example, surgery for hardware removal).
  - This section shall also not apply to any Covered Charge for testing and any follow up vaccination with respect to an Injury that involves a potential occupational exposure to a bloodborne pathogen.

Approved Medical Provider and Pre-Authorization Requirements

The cost of a service or supply shall be a Covered Charge only if:

- Treatment is (1) furnished by or under the direction of an Approved Medical Provider, acting within the scope of the Approved Medical Provider's license, and (2) pre-authorized by the Claims Administrator (except when the Claims Administrator determines that prior authorization was impossible under the circumstances). A single pre-authorization may include authorization for multiple visits to an Approved Medical Provider; or
- Treatment is provided as Emergency Care and (1) the Claims Administrator receives notification of such Emergency Care within the later of 24 hours of your receipt of such care or the next business day; and (2) after receiving primary Emergency Care, subsequent treatments are provided by, or at the direction of, an Approved Medical Provider in accordance with the paragraph above.

  An Emergency Care determination solely relates to consideration of an exception to the Plan's approved medical provider requirements. Any decision by you to seek treatment from an urgent care clinic or hospital emergency room does not necessarily involve Emergency Care. An Emergency Care determination shall be made within the sole administrative discretion of the Claims Administrator or Appeals Committee, with such advice and consultation from an Approved Physician as the Claims Administrator or Appeals Committee deems appropriate.

Covered Medical Services and Supplies

Medical Services and Supplies That Can Be Verbally Authorized. Subject to the restrictions and limitations set out elsewhere in this booklet, Covered Charges that can be verbally authorized will include the cost of the following:

- Approved Physician visits at an Approved Facility (including charges for an emergency room), Approved Physician's office, or in the case of home health care, at your home. Such Covered Charges shall also include (1) charges for a registered nurse, x-rays, and laboratory tests conducted as part of an Approved Physician visit, and (2) second medical opinion services requested by the Claims Administrator;
- Medical supplies approved by the treating Approved Physician, including the following:
  - Prescription drugs (generic, unless trade name drugs are requested by an Approved Physician) and over-the-counter drugs such as analgesics prescribed by an Approved Physician;
  - Blood and other fluids (other than allergy, insulin, and similar drugs) injected into the circulatory system (but only to the extent not available through any refund or allowance by a blood bank or similar organization);
  - Oxygen and its administration;
  - Upon the written advice or prescription of an Approved Physician and only if obtained from an Approved Facility, rental or purchase of a wheelchair, assisted breathing apparatus, or other mechanical equipment necessary for the treatment of respiratory paralysis, and similar internal or external durable medical equipment designed primarily for therapeutic purposes;
  - Surgical dressings, bandages, splints, casts, crutches, syringes, needles, trusses, and braces dispensed by an Approved Medical Provider; and
  - Similar medical supplies approved by the Claims Administrator;
- Professional ground ambulance service, or if no other means of transportation can reasonably suffice to deliver the individual to the closest appropriate Approved Facility, air ambulance, regularly scheduled railroad, or airlines;
- Eyeglasses or contact lenses: one pair per Injury, inclusive of professional office visit charges; and
- External hearing aid: inclusive of professional office visit charges.

Medical Services and Supplies Requiring Written Authorization

Subject to the restrictions and limitations set out elsewhere in this Plan, Covered Charges shall also include the cost of the following so long as the Claims Administrator (or its designated medical case manager) approves such charges in advance and in writing (including electronic notice):

- Admission to an Approved Facility on an inpatient or outpatient basis, including semi-private room and board, ambulatory day surgery, anesthesia and its administration, and similar services;
- MRI, CAT Scan, nuclear medicine, radiology and pathology (including interpretive services) and similar testing;
- Speech, occupational and physical therapy provided by an Approved Physician or a licensed speech therapist, licensed occupational therapist or licensed physical therapist;
- Inpatient rehabilitation services provided in a medical rehabilitation hospital;
- Limited or temporary pain management services (for example, epidural steroid injections), but not including pain management programs;
- Surgery that restores a reasonable, normal pre-Injury functioning;

- Services by a dentist or licensed oral surgeon for treatment and repair of broken teeth, fractures and dislocations of the jaw, or the replacement of teeth (excluding temporomandibular junction dysfunction services);
- Home health care (with respect to physical needs only);
- Skilled nursing care, provided that an Approved Physician monitors your progress at least once during each 30-day period of confinement;
- Orthotics, arch supports, corrective shoes, special bras or girdles, corrective appliances, prosthesis, or any similar item;
- Mental health services, but only when such services are provided for mental or emotional damage or harm resulting from a Participant being the victim of, or witness to, a Traumatic Event occurring during such Participant's Course and Scope of Employment;
- Services rendered primarily for training, testing, evaluation, counseling, or educational purposes; and
- Reasonable travel, meal and lodging expenses related to approved medical treatment that requires travel greater than 20 miles from your residence (one way) unless the Claims Administrator determines that Good Cause exists for travel that is 20 miles or less. Mileage will be reimbursed at the Internal Revenue Service identified "Medical Purposes" rate, as periodically updated.

Non-Covered Medical Services and Supplies

While the Plan provides benefits for many medical expenses, the following expenses are **not** covered by the Plan:

- Expenses which are determined to not be Medically Necessary, as determined by the Claims Administrator;
- Expenses to the extent that exceed any fee schedule adopted by the Claims Administrator or the Usual and Customary charge for the same or similar treatment, services or supplies in your geographic area;
- Services or supplies to which your condition is persistently nonresponsive;
- Acupuncture, behavior modification, pain management programs, hypnosis, biofeedback, other forms of self-care or self-help training or any related diagnostic testing, or any service or supply ancillary to any of these treatments;
- Chiropractic treatment, chiropractic therapy or spinal manipulation services;
- Substance abuse services;
- Custodial care;
- Charges for the purchase, rental or repair of bedding, or environmental control devices, including, but not limited to, an air conditioner, humidifier, dehumidifier, or air purifier, and charges for jacuzzis, saunas, vans, or structural changes to your residence or moving expenses; or
- Charges for services performed by:
  - a person who normally lives with you;
  - your spouse;
  - a parent of you or your spouse;
  - a child of you or your spouse; or
  - a brother or sister of you or your spouse.

Treatment Prior to Denial

Any provision of this Plan to the contrary notwithstanding, the Employer may render first aid, or the Plan may pay for Emergency Care, pay Wage Replacement Benefits or pay for a medical evaluation or treatment, and

the Plan can still make a subsequent determination that you have not suffered a covered Injury or otherwise deny any or all further benefits under the provisions of this Plan.

Medical Provider Referrals

If the treating Approved Physician finds it necessary to refer you to another health care provider, the treating Approved Physician must notify you and the Claims Administrator of his or her desire to make the referral and the objectives of such referral. The Claims Administrator will provide advance approval or disapproval of all referrals (and may rescind any such approval at any time) based upon such criteria as the Claims Administrator may determine for the effective administration of the Plan.

No Interference with Patient-Provider Relationship

Although benefits under this Plan are conditioned on your use of only Approved Medical Providers, you remain entitled to seek any medical care that you deem appropriate from any provider of your choice at your own expense. **However, any medical expenses for this medical care will not be payable under this Plan.** The Employer, Claims Administrator, Appeals Committee, and their agents and delegates, shall not have any responsibility for the actual medical or other health care services provided by any Approved Medical Provider or other health care provider. Health care providers are not agents of the Plan, Employer, Claims Administrator, or Appeals Committee. The Plan, Employer, Claims Administrator, and Appeals Committee are not liable or responsible for the acts or omissions of any health care provider. The actual medical treatment or rehabilitation of any Injury remains the sole prerogative and responsibility of the attending Approved Physician and other health care providers based on their independent judgment for the provision of health care.

Independent Medical Evaluation or Medical Records Review

The Plan reserves the right to require a medical records review or independent medical evaluation from an Approved Physician selected by the Claims Administrator for purposes of determining benefits under this Plan. The Claims Administrator will weigh the findings of the treating Approved Physician and the Approved Physician providing the second opinion and make a benefit determination under the Plan.

Your Right to a Second Medical Opinion

If you disagree with the diagnosis or treatment recommended by the Approved Physician whose opinion is accepted by the Claims Administrator ("Physician A"), then you may request a second medical opinion. You then shall have the right to a one-time examination at your own expense by another physician ("Physician B"). This examination by Physician B will be solely for the purpose of evaluating your condition and making a treatment recommendation.

If the diagnosis and treatment recommended by Physician B is contrary to that of Physician A, then the Claims Administrator shall designate a peer review physician who will evaluate the medical records and advise the Claims Administrator, and who may designate another Approved Physician for a further medical examination. **If you refuse to be so examined, all benefits under the Plan may be suspended.** The diagnosis and/or recommended treatment of the peer review physician or this last Approved Physician will be controlling. The fees and related expenses of the peer review physician and this last Approved Physician will be paid by the Plan (although you will have the option of paying up to one-half of such fees and expenses).

When Medical Benefits Cease

Medical Benefits will cease upon the earliest of:

- the expiration of 156 weeks from the date of the Injury;
- the date you reach the Plan's Maximum Benefit Limit;
- involuntary termination of your employment with the Employer for Gross Misconduct;
- the date that you do not receive medical treatment from an Approved Medical Provider for a period of more than 60 days, unless the Claims Administrator determines that Good Cause exists or as otherwise specified herein;
- the date you reach Maximum Rehabilitative Capacity; or
- the date you fail to comply with the requirements specified under the CONTINUING BENEFITS section of this booklet.

REQUESTING BENEFITS

The following is a summary of the procedures for requesting benefits under this Plan. Also see the DETAILED CLAIM PROCEDURES in the next section of this booklet.

Notice of Injury

You (or your Representative) must provide notice of an Accident or Injury **immediately** to your Department Manager, the Human Resources Department or the Manager-in-Charge, no matter how minor the Accident or Injury appears to be.

- For an Injury due to an Accident, notice must be provided no later than 30 calendar days from the date of the Accident.
- For an Injury due to Occupational Disease or Cumulative Trauma, notice must be provided within 30 calendar days after (1) you are medically diagnosed with an Occupational Disease or Cumulative Trauma, or (2) you should have known of the Occupational Disease or Cumulative Trauma.

Providing Required Information

You (or your Representative) must complete an incident report form and medical authorization form by the end of the next calendar day after the date the Accident and/or Injury is reported.

- These forms must be submitted to your Department Manager, the Human Resources Department or the Manager-in-Charge (or such other person as the Claims Administrator may specify).
- You must provide verbal, written, or recorded statements, and provide such proof and demonstrations (relating to the Injury or any prior or subsequent damage or harm you suffered, in or out of the Course and Scope of Employment), in such manner and within such periods, as the Claims Administrator may direct from time-to-time.

Good Cause

No benefits will be payable under the Plan if notice of Injury and required information is not provided as required above, unless the Claims Administrator determines that Good Cause exists.

CONTINUING BENEFITS

The Claims Administrator may suspend or terminate the payment of ongoing Plan benefits with respect to a claim if you violate one or more of the following provisions. **Unless the Claims Administrator determines that Good Cause exists, (1) a first violation shall result in a written warning and/or suspension of benefits, and (2) a second violation shall result in a termination of Plan benefits:**

- you do not receive prior approval for all medical care (other than Emergency Care);
- you utilize a non-approved medical physician or facility (other than Emergency Care);
- you refuse to submit to an independent medical examination by another Approved Physician selected by the Claims Administrator with respect to any surgical procedure, diagnosis or other treatment opinion rendered by the treating Approved Physician for which the Claims Administrator considers a second medical opinion advisable;
- you do not provide accurate information to, and follow the directions of, a treating Approved Physician. Following the directions of a treating Approved Physician includes, but is not limited to, any recommended treatment, therapy, course of action, abstinence or rehabilitation program;
- you fail to keep a scheduled appointment with an Approved Medical Provider;
- you do not (1) timely inform your Department Manager, the Human Resources Department or the Manager-in-Charge that you have been released by an Approved Physician to return to full or Modified Duty, (2) timely report to work in accordance with such work release, or (3) perform Transitional Duty in accordance with the Approved Physician's assigned work restrictions;
- you fail to fully cooperate with the Claims Administrator in connection with providing information to the Plan, including, but not limited to, providing incident reports and relevant medical records, submitting to a recorded statement and complying with the Plan's subrogation or coordination of benefits procedures;
- you are untruthful or demonstrate bad faith in connection with administration of the Plan; or
- you fail or refuse to comply with any other provisions of the Plan or the rules and procedures adopted by the Claims Administrator for the administration of the Plan.

DETAILED CLAIM PROCEDURES

Filing a Claim for Benefits

An initial claim for Medical Benefits, Wage Replacement Benefits, or Dismemberment Benefits under the Plan will be initiated by you (or your Representative) complying with the injury notice and medical treatment requirements found in the REQUESTING BENEFITS and MEDICAL MANAGEMENT sections of this booklet. A claim for Medical Benefits can also be directly submitted to the Claims Administrator by a health care provider (for example, submitting a written pre-authorization request for your medical treatment or submitting invoices for medical treatment you have already received). A claim for Death Benefits under the Plan shall be initiated by a Beneficiary providing written or electronic notice of entitlement thereto to the Claims Administrator within 90 days after the date of your death.

- **What is a Claim:** Each (1) medical service or supply for which payment is requested, (2) Wage Replacement Benefit for a particular payroll period, or (3) claim for Dismemberment Benefits or Death Benefits, will be deemed a separate "claim" for benefits that is subject to a determination under the Plan. The Plan's payment of a particular claim (for example, payment for an initial medical evaluation, even on a claim that may have been reported late) does not waive or otherwise prejudice the Claims Administrator's or Appeals Committee's right to deny another particular claim or all future claims for benefits under the

Plan. Any failure by the Claims Administrator or Appeals Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Claims Administrator's or Appeals Committee's authority to apply such provisions thereafter.

- Who is a Claimant: A claimant may file a claim for benefits under the Plan, as well as an appeal of an Adverse Benefit Determination. References in this DETAILED CLAIM PROCEDURES section to "claimant" may include you, a health care provider seeking payment for a service or supply, or a claimant's authorized Representative, as applicable. The Plan shall have the right to establish reasonable procedures for determining whether and to what extent an individual has been authorized to act on your behalf. However, with respect to an Urgent Care Claim, a physician or other health care professional (1) licensed, accredited or certified to perform specified health services consistent with state law, and (2) with knowledge of a claimant's medical condition shall be permitted to act as the authorized Representative of the claimant.
- Information to Submit: Claims must include the information required by the REQUESTING BENEFITS section above and such other reasonable information requested by the Claims Administrator, such as medical records or a written statement from an independent service provider evidencing the date, type of services rendered, and the total cost of such services. In addition, the Claims Administrator may require the claimant to provide a written and signed statement that provides that the amounts requested for payment under this Plan have not been reimbursed, or are not reimbursable under any other plan or program. See the OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFITS section of this booklet. The Claims Administrator may rely upon all such information furnished by the claimant, including the claimant's current mailing address, and shall have no obligation or duty to locate a claimant.
- Submission of Medical Bills for Payment: Approved Medical Providers will be requested to invoice all healthcare-related charges directly to the Claims Administrator (or the Employer, which will immediately transmit such invoice to the Claims Administrator). However, in the event that you receive such an invoice or pay such a charge, you must file all requests for payment or reimbursement of covered charges with the Claims Administrator within 30 days from the date such expenses are incurred or, if later, the date you receive an invoice from an Approved Medical Provider, or other health care provider (in the case of Emergency Care) for such expenses.
- Incomplete Claim Submissions: If a claim, as originally submitted, is not complete, the Claims Administrator will notify the claimant in the manner described below, and the claimant will have the responsibility for providing the missing information. Subject to the applicable provisions of this DETAILED CLAIM PROCEDURES section, if the period of time for a particular claim is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination will be suspended from the date on which the notification of the extension is sent to the claimant until the date on which the Claims Administrator receives the claimant's response to the request for additional information.
- Impartiality: The Plan shall ensure that all claims and appeals for benefits are determined in a manner designed to ensure independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or similar matters with respect to any individual (such as a claims adjuster or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Timing of Notice of Initial Benefit Determination

An initial benefit determination that approves Plan benefits can be communicated verbally, in writing or by electronic notice. Except as described below with respect to an Urgent Care Claim, an initial benefit

determination that is an Adverse Benefit Determination must be provided in writing or by electronic notice. The Claims Administrator will provide notice to the claimant of its initial benefit determination as follows:

- **Urgent Care Medical Benefit Claims:** In the case of an Urgent Care Claim for Medical Benefits, the Claims Administrator will notify the claimant of the Plan's initial benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies of the particular claim, but not later than 72 hours after receipt of the claim.
- Notification of an Adverse Benefit Determination for an Urgent Care Claim may be provided to the claimant orally within the timeframes specified above, provided that the oral notification satisfies the requirements of this subsection and that a written or electronic notice satisfying the requirements of this subsection is furnished to the claimant not later than 3 days after the oral notification.
- If the claimant (1) fails to follow the Plan's procedures for filing an Urgent Care Claim, or (2) otherwise fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan on an Urgent Care Claim, then the Claims Administrator will have the following additional notice requirement. This notice requirement will only apply to the extent that such failure is a communication by a claimant that is received by the Claims Administrator, and the communication names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.
  - The Claims Administrator will notify the claimant as soon as possible, but not later than 24 hours after its receipt of the claim, of the procedure to follow or the specific information necessary to complete the claim. Notification may be oral, unless the claimant requests written notice.
  - The claimant will then be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to correct such failure.
  - The Claims Administrator will then notify the claimant of the Plan's initial benefit determination as soon as possible, but not later than 48 hours after the earlier of (1) the Claims Administrator's receipt of the specified information necessary to complete the claim, or (2) the end of the time period given the claimant to provide such information.
- Concurrent Medical Care Decisions: If the Claims Administrator has approved an ongoing course of medical treatment to be provided over a period of time or number of treatments:
  - The Claims Administrator will notify the claimant of any reduction or termination by the Plan of such course of treatment. Such reduction or termination will be considered an Adverse Benefit Determination and the Claims Administrator will notify the claimant sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a benefit determination on review before the course of treatment is actually reduced or terminated.
  - Any request by a claimant to extend the course of treatment beyond the prescribed period of time or number of treatments previously approved by the Plan that is an Urgent Care Claim will be decided as soon as possible, taking into account the medical exigencies of the claim, as follows:
    - The Claims Administrator will make an initial benefit determination, whether adverse or not, within 24 hours after its receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.
    - Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving an Urgent Care Claim or not, will be made in accordance with the “Manner and Content of Adverse Benefit Determinations” section of this booklet.

- **Pre-Service Medical Benefit Claims:** In the case of a Pre-Service Claim for Medical Benefits, the Claims Administrator will notify the claimant of the Plan's initial benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after its receipt of the claim.
  - If the claimant fails to follow the Plan's procedures for filing a Pre-Service Claim, then the Claims Administrator will notify the claimant as soon as possible, but not later than 5 days after its receipt of the claim, of the procedure to follow. This notice requirement will only apply to the extent that such failure is a communication by a claimant that is received by the Claims Administrator, and the communication names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.
  - The Claims Administrator may extend the 15-day benefit determination period up to an additional 15 days if it determines that, due to matters beyond the control of the Plan, an initial benefit determination cannot be made within the first 15-day period, and notifies the claimant of the special circumstances requiring the extension and the date by which the Plan expects to render a decision.
  - If additional information is necessary to decide the claim, the extension notice shall specifically describe the required information and the claimant shall then be given at least 45 days to provide the specified information. However, the Claims Administrator's timeframe for making a benefit determination shall be suspended until the date upon which the claimant responds to the request for additional information.
- **Post-Service Medical Benefit Claims and Wage Replacement Benefit Claims:** In the case of a Post-Service Claim for Medical Benefits or a claim for Wage Replacement Benefits, the Claims Administrator will notify the claimant of an Adverse Benefit Determination within 30 days after its receipt of the claim.
  - The Claims Administrator may extend this period up to an additional 15 days if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan. Notice of such extension must be provided to the claimant prior to the expiration of the initial 30-day period and state (1) the special circumstances requiring the extension, and (2) the date by which the Plan expects to render a decision.
  - If the extension relates to a claim for Wage Replacement Benefits, such notice will also state (1) the standards on which entitlement to benefits is based, and (2) unresolved issues that prevent a benefit determination on the claim and what additional information is needed to resolve those issues.
  - If additional information is requested with the extension notice, the claimant will have 45 days from the date of the notice of extension to provide the specified information. However, the Claims Administrator's timeframe for making a benefit determination shall be suspended until the date upon which the claimant responds to the request for additional information.
- **Dismemberment Benefit Claims and Death Benefit Claims:** In the case of a claim for Dismemberment Benefits or Death Benefits, the Claims Administrator shall notify the claimant of an Adverse Benefit Determination within 90 days after its receipt of the claim.
  - The Claims Administrator may extend this period up to an additional 90 days if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan.
  - Notice of such extension must be provided to the claimant prior to the expiration of the initial 90-day period and state (1) the special circumstances requiring the extension, and (2) the date by which the Plan expects to render a decision.

Manner and Content of Adverse Benefit Determinations

If the initial benefit determination is an Adverse Benefit Determination, the Claims Administrator will provide a written or electronic notice to the claimant. Any electronic notice shall comply with ERISA regulations that specify the standards for electronic disclosure of benefit plan information.

- General Requirements: The notification to the claimant shall be written in a manner calculated to be understood by the claimant and shall include:
  - The specific reason or reasons for the Adverse Benefit Determination;
  - References to the specific Plan provisions on which the Adverse Benefit Determination is based;
  - A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
  - A description of the Plan's review procedures and the time limits applicable to such procedures; and
  - A statement that following an Adverse Benefit Determination on review by the Appeals Committee, the Plan offers no further voluntary levels of appeal and that the claimant has a right to bring a legal action under ERISA section 502(a).
- **Additional Requirements for Medical Benefit Claims:** If the Adverse Benefit Determination is in response to a claim for Medical Benefits, the notice shall include the following additional information:
  - If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, a statement that such rule, guideline, protocol or other similar criterion was relied upon and that a copy thereof shall be provided free of charge to the claimant upon request;
  - If the Adverse Benefit Determination is based upon medical necessity, an experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the Adverse Benefit Determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation shall be provided free of charge upon request; and
  - If the initial Adverse Benefit Determination is in response to an Urgent Care Claim, a description of the expedited review process applicable to such claims.
- **Additional Requirements for Wage Replacement Benefit Claims:** If the Adverse Benefit Determination is in response to a claim for Wage Replacement Benefits, the notice shall be provided in a culturally and linguistically appropriate manner (as described in this DETAILED CLAIM PROCEDURES section) and shall include the following additional information:
  - A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professional who evaluated the claimant;
    - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;
  - If the Adverse Benefit Determination is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Benefit Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

Filing an Appeal

Except as otherwise provided below, the claimant may appeal in writing an initial Adverse Benefit Determination to the Appeals Committee within 180 days following his or her receipt of the Adverse Benefit Determination from the Claims Administrator.

- The claimant may submit written comments, documents, records, and other information relating to the claim for benefits, and the Appeals Committee will take all of such information into account when reviewing the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- The claimant may receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information that is relevant to the claimant's claim for benefits (as determined by the Appeals Committee).
- In the case of an Adverse Benefit Determination of an Urgent Care Claim for Medical Benefits, the claimant may request orally or in writing an expedited review of the Adverse Benefit Determination and all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile or other available expeditious method.
- In the case of an Adverse Benefit Determination of a Dismemberment Benefit Claim or a Death Benefit Claim, the claimant may appeal in writing an initial Adverse Benefit Determination to the Appeals Committee within 60 days following his or her receipt of the Adverse Benefit Determination from the Claims Administrator.

Appeal Committee Review

When reviewing the appeal of an Adverse Benefit Determination for Medical Benefits or Wage Replacement Benefits, the Appeals Committee shall comply with the following requirements:

- The Appeals Committee review will not give any deference to the claimant's initial Adverse Benefit Determination.
- If the appeal request is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the Appeals Committee will consult with an Approved Physician who has appropriate training and experience in the field of medicine involved in the medical judgment. This Approved Physician will not be an individual who was consulted in connection with the initial Adverse Benefit Determination or a subordinate of such individual.
- Upon request of a claimant, the Appeals Committee will identify the individual names of any medical or vocational experts whose advice was obtained in connection with an initial Adverse Benefit Determination, without regard to whether the advice of such experts was relied upon in making the benefit determination.
- Before the Plan issues an Adverse Benefit Determination on review, the Appeals Committee shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or other person making the benefit determination (or at the direction of the Plan or such other

person) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided to the claimant, in order to give the claimant a reasonable opportunity to respond prior to the date.

- Before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, the Appeals Committee shall provide the claimant, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided to the claimant, in order to give the claimant a reasonable opportunity to respond prior to that date.

Timing of Notice of Benefit Determination on Review

The Appeals Committee will provide notice to the claimant, as described below, of the Plan's benefit determination on review in accordance with the following timeframes:

- **Urgent Care Medical Benefit Claims:** In the case of an Urgent Care Claim, the Appeals Committee will notify the claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies of the claim, but not later than 72 hours after its receipt of the claimant's appeal request.
- **Pre-Service Medical Benefit Claims:** In the case of a Pre-Service Claim for Medical Benefits, the Appeals Committee will notify the claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after its receipt of the appeal request.
- **Post-Service Medical Benefit Claims and Wage Replacement Benefit Claims:** In the case of a Post-Service Claim for Medical Benefits or a claim for Wage Replacement Benefits, the Appeals Committee will notify the claimant of the Plan's benefit determination on review within 45 days after its receipt of the appeal request. The Appeals Committee may extend this period up to an additional 45 days if the Appeals Committee determines that an extension is necessary due to matters beyond the control of the Plan. Written or electronic notification of an extension must be provided to the claimant prior to the expiration of the initial 45-day period and indicate (1) the special circumstances requiring the extension and (2) the date by which the Plan expects to render a decision.
- **Dismemberment Benefit Claims and Death Benefit Claims:** In the case of a claim for Dismemberment Benefits or Death Benefits, the Appeals Committee shall notify the claimant of the Plan's benefit determination on review within 60 days after its receipt of the appeal request. The Appeals Committee may extend this period up to an additional 60 days if the Appeals Committee determination that an extension is necessary due to matters beyond the control of the Plan. Written or electronic notification of an extension must be provided to the claimant prior to the expiration of the initial 60-day period and indicated (1) the special circumstances requiring the extension and (2) the date by which the Plan expects to render a decision.

Manner and Content of Benefit Determination on Review

The Appeals Committee will provide a claimant with written or electronic notification of the Plan's benefit determination on review. Any electronic notice shall comply with ERISA regulations that specify the standard for electronic disclosure of benefit plan information.

- **General Requirements:** If the determination on review is an Adverse Benefit Determination, the notice shall be written in a manner calculated to be understood by the claimant and shall include:

  - The specific reason or reasons for the Adverse Benefit Determination;
  - References to the specific Plan provisions on which the Adverse Benefit Determination is based;
  - A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
  - A statement of the claimant's right to bring an action under ERISA section 502(a).
- **Additional Requirements for Medical Benefit Claims:** If the Adverse Benefit Determination on review is in response to a claim for Medical Benefits, the notice shall include the following additional information:
  - The additional requirements for Medical Benefit claims described in this DETAILED CLAIM PROCEDURES section for the notice of initial benefit determinations; and
  - The following statement (if applicable): "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find what may be available is to contract your local U.S. Department of Labor Office and your State Insurance regulatory agency."
- **Additional Requirements for Wage Replacement Benefit Claims:** If the Adverse Benefit Determination on review is in response to a claim for Wage Replacement Benefits, the notice shall include the following additional information:
  - The additional requirements for Wage Replacement Benefit claims described in this DETAILED CLAIM PROCEDURES section for the notice of initial benefit determinations; and
  - With respect to the statement of claimant's right to bring an action under ERISA section 502(a), any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

Standards for Culturally and Linguistically Appropriate Notices

The Plan shall comply with the following standards for culturally and linguistically appropriate notices:

- **Claims Assistance:** The Plan shall provide oral language services that include answering questions in any applicable non-English language and shall provide assistance with filing claims and appeals in any applicable non-English language.
- **Claimant Requests:** The Plan shall provide, upon request, a notice in any applicable non-English language.
- **Notice:** The Plan shall include in the English version of all notices a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

Extension of Timeframes Allowed by Law or Agreement

In the event that ERISA rules and regulations permit additional time for decisions or actions by the Claims Administrator or Appeals Committee, the Claims Administrator or Appeals Committee may exercise their discretion to utilize (but not exceed) those extended timeframes.

- This discretion will only be exercised when necessary to provide a full and fair review of a claimant's right to benefits in accordance with the terms of this Plan (for example, additional time is needed to obtain an appointment and results of a medical examination).
- Upon request by the Plan, a claimant may also voluntarily agree to an extension or further extension of any time period within which the Plan must decide a claim.

Exhaustion of Administrative Remedies

No legal action can be brought by or with respect to you to recover benefits under the Plan before the foregoing claim procedures have been exhausted. Every ERISA right of action by you, your Representative, Beneficiary or estate against the Plan, or any Plan fiduciary, must be brought no later than one (1) year from the date that the foregoing claim procedures have been exhausted (due to claimant inaction, claimant receipt of a final Adverse Benefit Determination on appeal, or otherwise). Unless contrary to applicable law, any ERISA right of action or other legal action challenging a Plan decision shall be brought in the United States District Court for the Northern District of Texas, Dallas Division.

VOLUNTARY FINAL COMPROMISE AND SETTLEMENT

Not earlier than the tenth business day after the date of the initial report of injury and after you have received a medical evaluation from a non-emergency care doctor, the Claims Administrator may notify you of the Plan's desire to be released from any further known and unknown benefit and all other claims by you that are related to your Injury. If you (or your Representative) agree to this settlement, the Plan will pay a final claim settlement to (or with respect to) you and will accept no additional claims with respect to such Injury.

OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFIT

Offset of Benefits

Benefit payments under this Plan shall be reduced by:

- the amount of any applicable federal or state income, employment, or other taxes that are required by law to be withheld;
- your earnings from any employer after disability begins, amounts legally garnished, and your contributions (through salary reduction or otherwise) to a 401(k) or a 403(b) plan, cafeteria plan, or other pre-tax salary deferral employee benefit plan; and
- except as otherwise specified in the Plan's "Coordination of Benefits" section, any amount paid or available with respect to your Injury under the following: workers' compensation law, unemployment compensation law, disabilities benefits law, occupational disease law or any other similar law.

Coordination of Benefits

If you are covered under this Plan and one or more other benefit plans, then (unless otherwise subject to the "Subrogation and Reimbursement Rights" section) any Medical Benefits and Wage Replacement Benefits payable under this Plan will be either regular benefits or reduced benefits that, when added to the benefits of the other plan(s), will not exceed 100% of the amount described herein. The purpose of this provision is to prevent duplicate payments under plans that would exceed 100% of the benefits described in this Plan. In the coordination of benefits, one of the plans will be designated as the primary plan and the other plans will be designated as secondary. The primary plan will pay its full benefits first, then the secondary plan(s) will pay, but payments will be coordinated so that the total from all plans will not be more than the benefits described in this Plan. **Nothing in this Article shall be construed to coordinate benefits under the Plan with benefits under another group health plan.**

- Except as otherwise specified above with respect to group health plans, "other benefit plans" shall mean any health or disability-type benefits provided under (1) any individual, group, blanket or franchise plan, (2) other prepaid coverage under service plan contracts, or under group or individual plans, policies or a practice, (3) uninsured arrangements of group or group-type coverage, (4) labor-management trusteed

plans, labor organization plans, employer organization plans, or employee benefit organization plans, (5) benefits coverage in a group, group-type and individual policy or policies of automobile coverage (including, but not limited to medical payment coverage, personal injury protection coverage, uninsured motorists coverage and underinsured motorists coverage, and (6) any other group-type contracts – that is, those contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

- Except as specified below, if a person is covered by more than one plan to which this coordination of benefits provision applies, then the following rules will determine which plan will be primary:
  - With respect to health benefits only, when only one of the plans has a coordination of benefits provision, then the plan without such a provision will be the primary plan;
  - The plan under which the person is covered other than as a dependent (for example, active employee, former employee, inactive employee, COBRA participant or retiree) will be the primary plan over a plan which covers the person as a dependent;
  - The plan under which the person is covered as an active employee will be the primary plan over a plan which covers the person as former employee, inactive employee, COBRA participant or retiree; or
  - If none of these rules establish an order of benefit determination, then the plan that has covered the person for the longer period of time will be the primary plan.
- Any provision herein to the contrary notwithstanding, Medical Benefits payable under this Plan to or with respect to any person who is in "current employment status" as defined for purposes of Medicare, and who is eligible for benefits under Medicare, shall be primary and shall not be reduced by the amount of benefits payable to or with respect to such person under Medicare, which will be considered the secondary plan. However, Medical Benefits payable under this Plan to or with respect to any person who is not in "current employment status," as defined for purposes of Medicare, and who is eligible for benefits under Medicare, shall be secondary and reduced by the amount of all benefits payable to or with respect to such person under Medicare, which will be the primary plan.
- The fact that a person is eligible for or provided (1) medical assistance under a state plan, or (2) survivor benefits or retirement benefits under the Social Security Act, will not be taken into account in making payments under the Plan.
- You must notify the Claims Administrator of such other benefit plans and cooperate with the Claims Administrator in (1) furnishing copies of other policies, coverage or plans which may be applicable to the Injury, and in (2) completing and returning to such Claims Administrator any questionnaire or forms inquiring about, or assigning rights to recover under, other policies, coverage or plans which may cover or be applicable to you.

Subrogation and Reimbursement Rights

For purposes of “Subrogation and Reimbursement Rights”, the “Notice of Legal Proceedings,” and “Assignment of Rights” sections of this Plan, the term “Payee” means you or your Beneficiary or your respective family members, heirs, estate, or other Representative (in their individual or representative capacity), singularly or collectively as the context may require to give the Plan the broadest possible rights of recovery.

- **Right of Subrogation:** If a Payee becomes entitled to or directly or indirectly receives Plan benefits for any Injury caused by the negligence or other act or omission of any person or organization (including, but not limited to, the Employer), and is (or later becomes) entitled to or otherwise collects any damages or

other compensation in connection with such Injury (including, but not limited to, damages for negligence, survival, wrongful death or other legal or equitable action), whether by insurance, litigation, settlement or other proceeding, the Payee shall automatically be required to (i) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation to the extent of the Plan benefits paid to, or with respect to, the Payee and (ii) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation for all medical management, investigation, attorneys' fees, costs of recovery, and other expenses related to the claim for benefits (including any subrogation proceeding). The subrogation rights of this Plan even apply with respect to a Payee who is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Injury but has not and will not receive any Plan benefits if such person's claim for damages or other compensation is dependent on whether the participant had or has a valid claim against a third party.

- **Written Confirmation:** Upon request of the Plan, the Payee shall provide the Plan written confirmation of this subrogation right, including execution of any assignment, lien form or other document requested by the Claims Administrator to enable the Plan to recover such Plan benefits and related expenses. Any failure of a Payee to give written confirmation of the Plan's subrogation rights does not adversely affect its rights of subrogation because the Plan's right of subrogation arises automatically once payment under this Plan is made to or on behalf of the Payee.
- **Right to Reimbursement:** If (i) a Payee fails, refuses or neglects to reimburse the Plan or otherwise comply with the provisions of this section, or (ii) payments are made under the Plan based on fraudulent information or otherwise in excess of the amount necessary to satisfy the provisions of the Plan, then the Plan shall still have all remedies and rights of recovery specified herein. The Plan shall also have the right to terminate or suspend benefit payments and/or recover the reimbursement of all amounts above due to the Plan by withholding, offsetting and recovering such amounts out of any future Plan benefits or amounts otherwise due from the Plan to or with respect to such Payee.
- **Right of Recovery:** The Plan shall have the first lien recovery against any benefits paid or to be paid by the Plan. The Plan shall also have the right to bring a lawsuit and assert a constructive trust or other interest against any and all persons that have assets to which the Plan can claim rights. The Plan has the right of first recovery from any judgment, settlement or other payment, regardless of whether the Payee has been "made whole."
- **Attorney's Fees and Expenses:** The Plan's subrogation rights and first lien will not be reduced by attorneys' fees or expenses incurred by any party in pursuing recovery against a third party and the "common fund" doctrine shall not apply. Any attorneys' fees and/or expenses incurred by or at the request of the Payee or his, her or its attorneys in a third party or other action shall be the sole responsibility of such party.

Notice of Legal Proceedings

A Payee (whether or not such person has received or may in the future directly or indirectly receive Plan benefits) shall provide the Claims Administrator with prior written notice of the involvement of such party in any lawsuit, settlement discussion or other proceeding (for negligence, wrongful death, survival or other cause of action), one of the principal purposes of which is recovering, from any person or organization, damages or other compensation in any way related to any Injury for which Plan benefits have been or may in the future be paid. The Plan shall have the right to intervene for itself and on behalf of a Payee in any such lawsuit, settlement discussion or other proceeding. If a Payee neglects, fails or refuses to seek a recovery from any person or organization for any Injury caused by the negligence or other act or omission of such person or organization, the Plan shall have the right to institute a lawsuit or other proceeding or do any other act that in the opinion of the

Claims Administrator may be necessary or desirable to recover the Plan benefits paid (and to be paid in the future), plus all medical management, investigation, attorneys' fees, costs of recovery, and other expenses incurred by the Plan.

Assignment of Rights

By participating in this Plan, a participant obligates himself or herself, as well as all other Payees (in both their individual and representative capacities), to the provisions of this Plan, including, without limitation, the "Subrogation and Reimbursement Rights, "Notice of Legal Proceedings," and "Assignment of Rights" sections hereof. Upon the request of the Claims Administrator, a Payee shall assign to the Plan the right to intervene in or institute any lawsuit, settlement discussion, or other proceeding described in the "Subrogation and Reimbursement Rights, and "Notice of Legal Proceedings," sections, and to use the name of such party for such purpose. The Plan shall have the right to select legal counsel of its own choice and such counsel shall have complete control over the conduct of any such lawsuit, settlement discussion, or other proceeding without the consent or participation of any such Payee. Whenever the Plan shall intervene in or institute any lawsuit or other proceeding as permitted by the provisions of this section, the Plan may pursue same to a final determination and the Plan expressly reserves the right to appeal from any adverse judgment or decision. The Payee shall give the Plan all reasonable aid in any such lawsuit, settlement discussion, or other proceeding in effecting settlement, in securing evidence, in obtaining witnesses, or as may otherwise be requested by the Claims Administrator. The Payee shall release the Plan, the Employer, the Plan Administrator, the Claims Administrator, the Appeals Committee, and their respective directors, officers, agents, consultants, attorneys, and employees from all claims, causes of action, damages and liabilities of whatever kind or character that may directly or indirectly arise out of the pursuit or handling by the Plan of any such lawsuit, settlement discussion or other proceeding.

Right to Receive and Release Necessary Information

The Claims Administrator may, without the consent of or notice to any person or organization, release to or obtain from any person or organization, information needed to implement Plan provisions. When you request benefits, you must furnish all information requested by the Claims Administrator.

APPLICABLE LAW

This Plan shall be governed and construed in accordance with the provisions of ERISA and, except where superseded by federal law, the laws of the State of Texas. This Plan is exempt from the group health plan requirements of:

- Part 7 of ERISA by operation of one or a combination of the excepted benefits listed in ERISA Section 733(c)(1) and is therefore exempt from the standards, rules, regulations and other requirements of the Health Insurance Portability and Accountability Act ("HIPAA");
- The Public Health Service Act by operation of one or a combination of the excepted benefits listed in Title 42 of the United States Code Section 300gg-91(c)(1) and is therefore exempt from the standards, rules, regulations and other requirements of the Patient Protection and Affordable Care Act ("PPACA"); and
- Any other standards, rules, regulations or other requirements that utilize or reference the excepted benefits definition listed in ERISA Section 733(c)(1).

AMENDMENT OR TERMINATION OF PLAN

The Company presently intends to continue the Plan indefinitely, but the Company reserves the right to amend, modify, or terminate the Plan at any time. However, that no such amendment or termination will reduce the amount of any benefit payable to, or with respect to, you under the Plan in connection with an Injury occurring prior to the date of such amendment or termination. Any such amendment or termination will be adopted pursuant to formal written action of a representative authorized to act on behalf of the Company.

DEFINITIONS

This section defines specific terms used in this booklet. These definitions should not be interpreted to extend coverage unless specifically provided for in the other sections of this booklet and the Plan document.

Adverse Benefit Determination

"Adverse Benefit Determination" means a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Plan benefit. An "Adverse Benefit Determination" may also be a denial, reduction, termination, or failure to provide or make payment that is based on a determination of your or your Beneficiary's eligibility to participate in the Plan.

- With respect to a claim for Medical Benefits, the term "Adverse Benefit Determination" includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service (for which benefits are otherwise provided) because the item or service is determined to be experimental, investigational or not Medically Necessary or appropriate.
- With respect to a claim for Wage Replacement Benefits, the term "Adverse Benefit Determination" also means any rescission of your Wage Replacement Benefit coverage (whether or not, in connection with the rescission, there is an adverse effect on a particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect.

Appeals Committee

The designated decision maker appointed by the Plan Administrator to make determinations on appeal of benefit claims. The Appeals Committee's fiduciary responsibility is limited to discretionary authority and ultimate decision-making authority with respect to any final appeals of denied claims. The Appeals Committee shall otherwise hold no further authority, responsibility or liability as related to the administration of the Plan.

Approved Facility

A hospital, urgent care center, medical rehabilitation hospital, skilled nursing facility, or other medical care facility either approved by the Claims Administrator or included on an approved list of facilities adopted by the Claims Administrator.

Approved Medical Provider

An Approved Facility, Approved Physician or other health care service or supply provider either approved by the Claims Administrator or included on the approved list of medical providers adopted by the Claims Administrator. The Claims Administrator reserves the right to add to, delete from, or otherwise amend any list of Approved Medical Providers at any time.

Approved Physician

A person duly licensed under applicable state law as a Medical Doctor or Doctor of Osteopathy and either approved by the Claims Administrator or included on an approved list of physicians adopted by the Claims Administrator.

Beneficiary

The person or persons determined in the following priority:

- If there is an Eligible Spouse, Death Benefits shall be paid to the Eligible Spouse.
- If there is no Eligible Spouse, Death Benefits shall be paid in equal shares to the Eligible Children.
- If you are not survived by an Eligible Spouse or Eligible Child, Death Benefits shall be paid to your surviving dependent (as determined in accordance with the support criteria set forth in section 152 of the Internal Revenue Code and such other rules as the Claims Administrator may prescribe) who is your parent, sibling, or grandparent. If more than one of those dependents survives you, any Death Benefits shall be divided among them in equal shares.
- If you are not survived by an Eligible Spouse, Eligible Child, or dependent who is a parent, sibling, or grandparent, Death Benefits shall be payable to your estate.
- For purposes of this Section:
  - "Eligible Spouse" means your surviving Spouse or Domestic Partner:
    - “Spouse” means a person (whether of the opposite gender or the same gender) who is lawfully married to you under the laws of the state or country in which the relationship was created (regardless of where the married couple is currently domiciled).
    - “Domestic Partner” means (i) a person (whether of the opposite gender or same gender) who has entered with you into a registered domestic partnership, civil union, or other similar formal relationship recognized under the laws of the state or country in which the relationship was created, and (ii) such formal relationship is not denominated as a marriage under the laws of the state or country in which the relationship was created.
  - "Eligible Child" means your surviving child, whether by blood, marriage, or legal adoption, and for which the parent-child relationship has been legally established prior to the date of your death by evidence of birth certificate, adoption decree, or other court decree of paternity or maternity, if the child is:
    - under 18 years of age;
    - enrolled as a full-time student in an accredited educational institution and is less than 26 years of age; or
    - because of a physical or mental handicap, your dependent (as determined in accordance with the support criteria set forth in section 152 of the Internal Revenue Code and such other rules as the Claims Administrator may prescribe) at the time of your death.

Claims Administrator

The individual, individuals or entity appointed by the Company to make initial determinations of benefit claims under this Plan.

Course and Scope of Employment

An activity of any kind or character for which you were hired and that has to do with, and originates in, the work, business, trade or profession of the Employer, and that is performed by you in the furtherance of the affairs or business of the Employer. The term includes activities conducted on the premises of the Employer or at other locations designated by the Employer. This term does not include:

- transportation to and from your place of employment, unless:
  - the transportation is furnished as part of your employment arrangement or is paid for by the Employer; provided, however, that this exception does not include commuting to or from your usual place of employment;
  - the means of the transportation are under the control of the Employer; or
  - you are directed in your employment to proceed from one place to another place. Commuting to the place where you begin Employer business and commuting away from the place where you cease Employer business will not be covered if such transportation is not paid for by the Employer or otherwise under Employer control.
- travel by you in furtherance of the affairs or business of the Employer if such travel is also in furtherance of personal or private affairs by you, unless:
  - the travel to the place where the Injury occurred would have been made even had there been no personal or private affairs by you to be furthered by the travel; and
  - the travel would not have been made had there been no affairs or business of the Employer to be furthered by the travel.
- any injury occurring before you clock in or otherwise begin work for an Employer, or after you clock out or otherwise cease work for an Employer unless the Injury occurs on the Employer's premises (or other area for which an Employer is responsible for maintenance) and you are proceeding directly to or from work.
- any injury occurring while you are on a work break, unless:
  - the injury occurs while you are on a permitted work break on the Employer's premises (or other area for which an Employer is responsible for maintenance); and
  - you are scheduled to return to work that same day following such work break.
- any injury that results from personal property (not originating in the Employer's workplace) while you are engaged in eating, restroom breaks or similar personal comfort activities.
- any injury occurring as a result of personal shopping, personal errands, or similar personal deviations from your work activities, as determined by the Claims Administrator.

Disabled or Disability

A Total Disability or a Partial Disability:

- A "Total Disability" means a medically demonstrable anatomical or physiological abnormality caused by an Injury, which causes you to be -
  - unable to perform the normal duties for which you were employed;
  - under the regular care of an Approved Physician; and
  - unable to engage in Transitional Duty or any other occupation for wage or profit.

- A “Partial Disability” means a medically demonstrable anatomical or physiological abnormality caused by an Injury that results in you being –
  - unable to fully perform the normal duties for which you were employed;
  - under the regular care of an Approved Physician;
  - released to Transitional Duty by such Approved Physician; and
  - working for the Employer in a Transitional Duty position approved by the Employer.

Emergency Care

A service or supply provided with respect to a medical condition manifesting itself by a sudden and unexpected onset of acute symptoms of sufficient severity that in the absence of immediate medical attention could reasonably be expected to (1) result in death, disfigurement, or permanent disability, or (2) result in substantial impairment of any bodily organ, part, or function.

Good Cause

Circumstances existed that you could not foresee and were beyond your control. As part of its evaluation, the Claims Administrator may require you and Employer to produce evidence in order to establish the existence of good cause. The Claims Administrator shall examine the evidence from its evaluation in order to determine whether good cause exists in a particular circumstance.

Gross Misconduct

Your gross misconduct within the meaning of Section 4980B of the Internal Revenue Code, or any successor provision of law. Gross misconduct typically means more than momentary thoughtlessness, inadvertence, or error of judgment. It means such an entire want of care as to establish that the act or omission in question was the result of actual conscious indifference to the rights, welfare, or safety of the persons or Employers affected by it.

Making the Safey Commitment

The form attached to the back of this SPD booklet.

Maximum Benefit Limit

The maximum amount of all benefits payable to you under the Plan with respect to an Injury. Payments made for each form of benefit will be counted towards the Maximum Benefit Limit amount. The Maximum Benefit Limit for this Plan is $1,000,000; provided, however, that the aggregate amount of the Maximum Benefit Limits with respect to claims of all participants arising out of a single Accident, or related series of Accidents, or Occupational Disease or Cumulative Trauma exposure, will not exceed $1,000,000. This aggregate amount may proportionally reduce the Maximum Benefit Limit applicable to each participant involved in such Accident, related series of Accidents, or exposure, in such manner as the Claims Administrator or Appeals Committee may determine.

Maximum Rehabilitative Capacity

The earliest date after which, based upon reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated.

Medically Necessary

Services, procedures or supplies which are:

- required, recognized, and professionally accepted nationally by physicians as the usual, customary and effective means of diagnosing or treating the condition;
- the most economical supplies or levels of service that are appropriate and available for your safe and effective treatment; and
- not primarily for your convenience or that of your family, a physician, or a facility.

Even though a physician may have prescribed a particular treatment, such treatment may not be considered Medically Necessary within this definition or may otherwise be excluded from coverage under the terms of the Plan.

Plan

Nordstrom, Inc. Injury Benefit Plan For Texas Employees

Plan Administrator

The Company is the plan administrator of the Plan for purposes of ERISA. The Plan is administered on behalf of the Company by the Claims Administrator and Appeals Committee.

Subject to the Plan claim procedures, both the Claims Administrator and the Appeals Committee have discretionary authority to interpret and implement the provisions of the Plan. Any failure by the Claims Administrator or Appeals Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Claims Administrator's or Appeals Committee's authority to apply such provisions thereafter. Every interpretation, choice, determination, or other exercise of authority by the Claims Administrator or Appeals Committee will be binding upon all affected parties, without restriction, however, on the right of the Claims Administrator or Appeals Committee to reconsider and re-determine such action. There shall be no “de novo” review by any arbitrator or court of any decision rendered by the Appeals Committee and any review of such decision shall be limited to determining whether the decision was so arbitrary and capricious as to be an abuse of discretion. The Claims Administrator or Appeals Committee may adopt any rules and procedures it considers necessary or appropriate for the administration of the Plan. The Claims Administrator or Appeals Committee may deny a claim for or suspend the payment of Plan benefits otherwise payable to you if you do not comply with any provision of the Plan or the rules and procedures adopted by the Claims Administrator or Appeals Committee.

Post-Service Claim

Any claim for a Medical Benefit that is not a Pre-Service Claim. A Post-Service Claim **shall include**, but not be limited to, a determination involving (1) initial eligibility for Plan benefits, or (2) termination of ongoing eligibility for Plan benefits.

Preexisting Condition

Your illness, injury, disease, impairment or other physical or mental condition, whether or not work-related, which originated or existed prior to the date of the Injury.

Pre-Injury Pay

- For a salaried participant, regular bi-weekly salary from the Employer at the time of the Injury; and

- For hourly participants, the average weekly wage from the Employer for the 52 consecutive weeks immediately preceding the date of Injury; provided, however, that if such a participant has worked for the Employer for less than 52 consecutive weeks, or if his or her earnings as of such date cannot be reasonably determined (in the judgment of the Claims Administrator), such 52-week average will be based upon the earnings received over such period by a similar employee of the Employer.

"Pre-Injury Pay" **shall include** pay for overtime, commissions, and participant contributions (through salary reduction or otherwise) to a 401(k) arrangement, cafeteria plan, or other pre-tax salary deferral employee benefit plan. "Pre-Injury Pay" **shall not include** any bonuses, benefits (including, but not limited to, Employer contributions to any employee benefit plans or matching contributions to a retirement plan) or other extraordinary remuneration.

Pre-Service Claim

Any claim for Medical Benefits related to a specific diagnostic test, procedure, hospital admission or similar medical treatment with respect to which this Plan requires Claims Administrator approval in advance of obtaining medical care. A Pre-Service Claim **shall not include** any determination involving (1) initial eligibility for Plan benefits, or (2) termination of ongoing eligibility for Plan benefits.

Representative

A person that you authorize in writing to act on your behalf. The Plan will also recognize a legally valid power of attorney or a court or administrative agency order giving a person authority to take an act on your behalf. In the case of an Urgent Care Claim, a physician with knowledge of your condition may act as your Representative.

Transitional Duty

A temporary accommodation that allows you to perform your regular job, or an alternate, temporary job that complies with your work restrictions and the Employer's needs.

Traumatic Event

Any act involving, or of the nature of, violent crime or any other incident that would result in severe shock to a reasonable person.

Urgent Care Claim

Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent Pre-Service Claim determinations (generally, 15 days after the Claims Administrator's receipt of the claim):

- could seriously jeopardize your life or health or your ability to regain maximum function; or
- in the opinion of a physician with knowledge of the claimant's medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim is an Urgent Care Claim as described above shall be made by the Claims Administrator applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of the claimant's medical condition determines that a claim is

an Urgent Care Claim and clearly communicates such determination to the Claims Administrator, the Plan shall treat the claim as an Urgent Care Claim for purposes of this Plan.

The characterization of a claim as an Urgent Care Claim solely impacts the timeframes and other procedures for processing benefit claims and in no way changes this Plan's approved medical provider requirements, pre-authorization requirements, or other medical management requirements. Urgent Care Claims may not rise to the level of involving Emergency Care. Your decision to seek treatment from an urgent care clinic or hospital emergency room does not necessarily result in an Urgent Care Claim or involve Emergency Care. See the MEDICAL BENEFITS and DETAILED CLAIM PROCEDURES sections of this booklet for more information.

Usual and Customary

A charge that is not more than the amount charged by a health care provider when there is no insurance or other third party reimbursement, and is not more than the prevailing and customary charge in the locality for a like treatment, service or supply.

- A "like treatment or service" is one of the same in nature and duration, requiring the same skill and performed by one of similar training and experience.
- A "like supply" is one which is the same or substantially equivalent.
- "Locality" is the city or town where the service or supply is obtained, if it is large enough so that a representative cross-section of like services or supplies can be obtained. In large cities, it may be a section or sections of the city, if the above criteria can be met. In smaller urban or rural areas, locality may have to be expanded to include surrounding areas to arrive at a representative cross-section.

GENERAL INFORMATION

Type of Plan and Administration

The Plan is a welfare benefit plan providing wage replacement, death, dismemberment and medical benefits (including certain dental and vision benefits) due to an Injury. The Plan is administered by the Claims Administrator and Appeals Committee to the extent such duties have been delegated to the Claims Administrator and Appeals Committee by the Plan Administrator.

Name and Address of Plan Sponsor

Nordstrom, Inc.
1700 7th Avenue, 15th Floor
Seattle, WA 98101

A list of the employers of Nordstrom, Inc. participating in this Plan is available by request by calling or writing to the Plan Administrator.

Name and Address of Plan Administrator

Any questions you may have about the Plan may be posed to the Plan Administrator by mail, c/o Risk Management, at P.O. Box 25799, Santa Ana, California 92799, or by telephone at 888.916.5700.

Name and Address of Person Designated as Agent for Service of Legal Process

CT Corporation System
350 N. St. Paul St.
Dallas, TX 75201

Service of legal process may also be made upon the Plan Administrator.

Employer and Plan Identification Numbers

The employer identification number assigned by the Internal Revenue Service to Nordstrom, Inc. is 91-0515058. The plan number of the Plan is 502.

Plan Year

The Plan operates and keeps its records on a 12-month period ending each January 31.

ERISA RIGHTS STATEMENT

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as work sites) all documents governing the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

Continue group health coaverage for yourself if there is a loss of coverage under the plan as a result of a qualifying event. You may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy

of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have brought a claim against to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if it finds your claim is frivolous.

Assistance with Your Questions

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

April 1, 2016

APPENDIX A: COBRA CONTINUATION COVERAGE

NOTICE: The following provisions have been provided for purposes of complying with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). Please note, however, that group health benefits provided under the Plan are limited to treatment of injuries which are sustained during the Course and Scope of Employment with an Employer. Therefore, continuation of group health coverage would not be practical if you experienced a termination of employment with the Employer for whatever reason.

In addition, if you have a covered Injury during your employment with an Employer, the Plan would continue to provide you with health benefits for that Injury following your termination of employment (subject to the terms and limits in this Plan), unless such employment was terminated based upon Gross Misconduct. Therefore, termination of employment of employment in this situation would not be a "Qualifying Event" under COBRA because it does not result in a loss of coverage under the Plan.

Finally, the Plan does not provide coverage for dependents. Therefore, any continuation coverage provided under COBRA with respect to dependents would not be applicable to this Plan.

1.1 Right to COBRA Coverage. **A Participant who is a Qualified Beneficiary (as hereafter defined) will have the right to continue health coverage under the terms of the Plan, as limited by this Appendix, if such Participant experiences a Qualifying Event (as hereafter defined). To the extent required by Federal law, the Plan Administrator or its duly authorized representative shall provide each Participant written notice of his or her right to apply for continued coverage. Such notice will be provided by the Plan Administrator or its duly authorized representative immediately following commencement of participation in the Plan and within 14 days following the later of (i) the date of the Qualifying Event or (ii) the date that the Administrator receives notice of a Qualifying Event (provided notice is given to the Administrator within the timeframe required by law). Notification in any form and manner permitted by COBRA shall be deemed to satisfy this requirement.**

1.2 Individual Election of Coverage. **Each Qualified Beneficiary will have an independent right to elect continued coverage under the Plan on his or her behalf. A Qualified Beneficiary can also elect to continue coverage under the Plan on behalf of any other Qualified Beneficiary that resides at the same address.**

1.3 Election Deadline.

(a) General Rule. An election to continue coverage under the Plan must be made by such means of making an effective election as established by the COBRA Administrator. Such election must be made with the COBRA Administrator within 60 days following the later of (i) the date coverage ends because of the Qualifying Event, or (ii) the date on which the Qualified Beneficiary received notification of the right to continue coverage. Failure to elect continued coverage within that 60-day period will mean a permanent loss of the Qualified Beneficiary's right to continue coverage under this Article.

(b) Election After Waiver. If a Qualified Beneficiary waived continuation coverage rights, the Qualified Beneficiary can revoke the waiver and elect continuation coverage at any time during the 60-day period described in paragraph (a) of this Section by making an affirmative election in the manner established by the COBRA Administrator.

1.4 Date Continued Coverage Begins. **If a Qualified Beneficiary elects coverage in accordance with Section 1.3, the Qualified Beneficiary's continued coverage will begin on the date that coverage otherwise would have ceased, provided the Qualified Beneficiary timely pays the premium as required in Section 1.6. If a Qualified Beneficiary elects coverage in accordance with Section 1.3(b) after a waiver of coverage, such Qualified Beneficiary's continued coverage will start no earlier than the first day of the month in which the Qualified Beneficiary makes the second election (i.e. the affirmative election of coverage) or the day the Qualified Beneficiary makes the second election (i.e. the affirmative election of coverage).**

1.5 Cost of Continued Coverage. **The person electing continued coverage must pay 102% (up to 150% for a disabled person) of the full cost (employer and employee portions) of such coverage for similarly situated Participants with respect to whom a Qualifying Event has not occurred. The cost of continued coverage will be established prior to the beginning of each Plan Year and may only be changed during a Plan Year as provided in Code Section 4980B-8 and Treasury Regulation section 54.4980B-8.**

1.6 Premium Payment.

(a) Payment Deadline.

(1) Initial Premium. The due date for payment of a Qualified Beneficiary's initial COBRA premium is 45 days from the date of his or her election to continue coverage. Failure to make a timely payment of the Qualified Beneficiary's first premium will result in a permanent loss of the Qualified Beneficiary's continued coverage rights.

(2) Subsequent Premiums. Premium payments subsequent to the initial payment will be due and payable to the Administrator prior to the first day of each month, with a 45-day grace period.

(b) No Coverage Until Premium Paid. Even though the Qualified Beneficiary has a 45-day period to pay the Qualified Beneficiary's first premium and a 45-day grace period to pay each subsequent monthly premium, a Qualified Beneficiary will not be considered to have continued coverage under the Plan for any period until the Qualified Beneficiary pays the premium with respect to that period. A Qualified Beneficiary's continued coverage will be retroactively reinstated if the Qualified Beneficiary pays the Qualified Beneficiary's premium within the appropriate period described in this Article.

1.7 When Coverage Ends. **Continued coverage will end on the earliest to occur of the events described in this Section. Continued coverage will end on the last day of the month in which the event occurs, except in the case of the events described in paragraph (f) under which continued coverage will end on the date of such event.**

(a) Maximum Period – General Rule. If a Qualifying Event occurs, coverage terminates 18 months from the date of the Qualifying Event, subject to the exceptions provided in this Section.

(b) Disability Extension. If a Qualifying Event occurs and the Qualified Beneficiary notifies the COBRA Administrator that a determination has been made under Title II or XVI of the Social Security Act that the Qualified Beneficiary was disabled at the time of the Qualifying Event (or at any time during the first 60 days of the 18-month coverage period), an additional 11 months of coverage is available after the normal termination date provided in paragraph (a) (i.e. coverage

terminates 29 months from the date of the Qualifying Event), but only if the Qualified Beneficiary has provided timely notice of such determination as required by Section 1.8 before the end of the original 18-month period.

(c) Coverage Under Another Nonsubscriber Plan. Coverage terminates if the Qualified Beneficiary first becomes covered (as an employee or otherwise) after the date of his or her COBRA election under any other nonsubscriber group health plan or Workers' Compensation insurance coverage made available to such individual pursuant to the Texas Labor Code that does not contain any exclusion or limitation (other than an exclusion or limitation that does not apply or is satisfied by such Qualified Beneficiary by reason of Code Section 9801) with respect to any actual Preexisting Condition of such Qualified Beneficiary. Regardless of whether such nonsubscriber plan or Workers' Compensation insurance coverage contains such an exclusion or limitation with respect to an actual Preexisting Condition of the Qualified Beneficiary, coverage will terminate when such exclusion or limitation no longer applies to the Qualified Beneficiary.

(d) Entitlement to Medicare. Coverage terminates on the date on which the Qualified Beneficiary first becomes enrolled under Medicare Parts A or B as provided under Title XVIII of the Social Security Act after the date of the COBRA election.

(e) Failure to Pay Premium. Continued coverage terminates as of the first day of any coverage period for which the applicable premium is not paid by the due date (including any 45-day extension of the due date caused by the grace period).

(f) Termination of Group Health Coverage. Coverage terminates on the date the Company ceases to provide any nonsubscription plan to any participant.

(g) End of Disability. With respect to each Qualified Beneficiary whose coverage is extended an additional 11 months under Section 1.7(b), coverage terminates on the first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary is no longer disabled. Upon such final determination, coverage terminates for the formerly disabled Qualified Beneficiary.

1.8 **Participant's Responsibility to Provide Notice. Any Qualified Beneficiary who is determined at the time of a Qualifying Event to have been disabled under title II or XVI of the Social Security Act must notify the COBRA Administrator within 60 days of such determination, and within 60 days of the date of any final determination under such title(s) that the Qualified Beneficiary is no longer disabled. Failure to give such notice within that 60-day period will result in a permanent loss of the right to continued coverage, or to additional continued coverage if the Qualified Beneficiary is on continued coverage at the time of the occurrence of such Qualifying Event.**

1.9 **Obligations of COBRA Participants. Elections, notices and payments must be delivered to the office of the COBRA Administrator as set forth on the notification of the right to continue coverage. Delivery of documents, and payment of premiums, relating to continued coverage will be considered to occur on the earlier of (i) the date of actual receipt by the COBRA Administrator, or (ii) the date deposited in the United States Mail, properly addressed and postage prepaid.**

In order to receive continuing coverage under this Appendix, each Qualified Beneficiary must (i) pay monthly premiums by the due date; (ii) promptly notify the COBRA Administrator of any address change; (iii) submit claims in the standard fashion as required by the Plan; (iv) elect desired plan

changes during annual enrollment as appropriate, in accordance with the applicable procedure; (v) report enrollment in any other group health coverage to the COBRA Administrator; and (vi) comply with any other requirements established by the COBRA Administrator from time to time.

1.10 **Definitions Used in this Appendix. For purposes of this Appendix, each of the following terms will have the meaning assigned to it, unless the context clearly requires otherwise:**

(a) "COBRA Administrator" means any entity or individual(s) engaged to provide administrative services to the Plan with respect to COBRA continuation coverage. The COBRA Administrator may, but need not be, a Claims Administrator under the Plan.

(b) "Qualified Beneficiary" means a participant covered by the Plan.

(c) "Qualifying Event" means, with respect to any participant, the last day of the month in which the following event occurs if, but for continued coverage provided under this Article, the occurrence of the event would result in loss of Plan coverage for a Qualified Beneficiary: the participant's termination of employment (other than for Gross Misconduct).

NORDSTROM

© Copyright 2016 PartnerSource