Summary Plan Description

For

NTESS Post-Employment Health and Welfare Benefits Plan
(For Employees Who Terminated Employment Before January 1, 2012)

Effective January 1, 2024

IMPORTANT

This Summary Plan Description (SPD) provides an overview of principal features of the NTESS Post-Employment Health and Welfare Benefits Plan ("Plan"). Additional information about Benefit Programs provided by this Plan is found in Appendix B. The documents referred to in Appendix B, as updated from time-to-time, are incorporated by reference into this SPD and the Plan.

The Board of Managers of National Technology & Engineering Solutions of Sandia, LLC (or its authorized delegate), in its sole discretion, at any time, reserves the right to amend or terminate (in writing) the Plan, the SPD, any Benefit Package or any Benefit Program offered by the Plan. No benefit described in the Plan, or the SPD will be considered to "vest."

This SPD will continue to be updated. Please check with the Post-Employment TPA for the most recent version.

For questions about Plan benefits, to receive a paper copy of this SPD, or to enroll in a Benefit Package or Benefit Program, please contact the Post-Employment TPA. Contact information can be found in Appendix H. SPDs are available electronically on the hr.sandia.gov website on the Plan Documents page.

NOTE: For health and welfare benefits provided to Employees who Terminate Employment on or after January 1, 2012, please see the *Summary Plan Description for NTESS Post-Employment Health and Welfare Benefits Plan (For Employees Who Terminate Employment on or after January 1, 2012)*. For health and welfare benefits provided to active Employees, please see the *Summary Plan Description for the NTESS Health and Welfare Benefits Plan for Active Employees.*

The NTESS Post-Employment Health and Welfare Benefits Plan (For employees who terminate employment Before January 1, 2012) Program's terms cannot be modified by written or oral statements to you from human resources representatives or any other NTESS personnel or the Post-Employment Third-Party Administrator(s).

U.S. DEPARTMENT OF ENERGY

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1. Introduction

A. General Information

This Summary Plan Description ("SPD") summarizes health and welfare benefits offered to Former Employees of National Technology & Engineering Solutions of Sandia, LLC (sometimes referred to as "Company" or as "NTESS") who Terminated Employment before January 1, 2012.[1]

The SPD contains information about Benefit Packages and Benefit Programs offered to eligible Former Employees and their eligible Spouses and Dependents pursuant to the NTESS Post-Employment Health and Welfare Benefits Plan ("Plan").

Benefit Program Materials referenced in Appendix B, together with updates (e.g., current Post-Employment Open Enrollment materials) are incorporated by reference into this SPD and the Plan. Medicare benefits are governed by the Medicare statute and regulations. See, Appendix I (Medicare) for additional information.

See the Glossary (Appendix G), for definitions of capitalized terms such as "Child," "Surviving Spouse," "Dependent," "Family Member," "Retiree," "LTD Terminee," "Terminate Employment," "YSA," and "Primary Covered Member."

Please share this SPD with your Family Members.

B. Plan Details

For more detailed information, please refer to:

- Appendix A for a Directory of Benefit Programs, including Cost Sharing, Financing, and Administration Information
- Appendix B for a list of Benefit Program Materials
- Appendix C and Section 12. Claims and Appeals Procedures for general claims and appeals administration information
- Appendix D for Eligibility Claims and Appeals Procedures
- Appendix E for Health Benefit Claims and Appeals Procedures
- Appendix F for Life Insurance Benefit Claims and Appeals Procedures
- Appendix G for a Glossary of terms used in this SPD
- Appendix H for Plan Administration Information
- Appendix I for Medicare background information

[1] For information about health and welfare benefits provided to Employees who Terminate Employment on or after January 1, 2012, please see the Summary Plan Description for NTESS Post-Employment Health and Welfare Benefits Plan (For Employees Who Terminate Employment on or after January 1, 2012). For information about health and welfare benefits provided to active NTESS Employees, please see, the Summary Plan Description for the NTESS Health and Welfare Benefits Plan for Active Employees.

- Appendix J for a Summary of Permitted Mid-Year Changes
- Appendix K for a summary of benefits available to Rehired Retirees

C. Post-Employment Third-Party Administrator

Throughout this Summary Plan Description, we refer to the Post-Employment Third-Party Administrator as the **Post-Employment TPA**. For example, the Post-Employment TPA is available to answer most questions about Benefit Packages and Benefit Programs offered under the Plan, and Primary Covered Members can contact the Post-Employment TPA to enroll, or disenroll, in a Benefit Program offered under the Plan. Please see, Appendix H for contact information for the Post-Employment TPA.

D. Sandia HR Solutions Organization

Periodically, we refer to HR Solutions in this Summary Plan Description. Participants can contact **HR Solutions** at 505-284-4700.

E. Keep Your Records Updated

Make sure the NTESS Post-Employment TPA has your current home address and telephone number.

2. Post-Employment Benefit Packages

The Company offers three Post-Employment Benefit Packages:

- Retiree Benefit Package
- Long Term Disability Terminee (LTD Terminee) Benefit Package
- Surviving Spouse Benefit Package

These packages can include medical, dental care and life insurance benefits listed in Appendix A, as that Appendix may be updated from time to time. Not all Employees who Terminate Employment with the Company are eligible for these Benefit Packages or for all Benefit Programs included in each Benefit Package.

Eligibility for Medical Benefit Program coverage included in these Benefit Packages is outlined below. Eligibility for Dental Care Benefit Program coverage included in these Benefit Packages is included in Section 3.

See, Section 4 and Section 5 for additional eligibility information.

Section 8 outlines life insurance benefits available to certain Retirees, and Section 9 outlines life insurance benefits available to certain LTD Terminees.

A. Retiree Benefit Package Below is information regarding eligibility for Retiree Medical Benefit Program coverage under the Plan's Retiree Benefit Package.

1. Service Pension Eligible Recipient. A Service Pension Eligible Recipient within the meaning of the NTESS Retirement Income Plan ("RIP") who begins receiving a Service Pension from the NTESS RIP is eligible for Retiree Medical Benefit Program coverage under a Retiree Benefit Package, if the recipient satisfies the requirements of this Section 2.A, the requirements of Section 6, and the requirements of Appendix K of this Summary Plan Description. Such a Service Pension Eligible Recipient is referred to below as a "Retiree."

2. Eligibility of Dependents. Retiree Medical Benefit Program coverage is available to the eligible Spouse and/or the Children of the Retiree. New Dependents (e.g., a Retiree's new Spouse or new Child) can be added during annual Post-Employment Open Enrollment or due to a Mid-Year Change in Status Event (see, Appendix J). If, however, the Spouse or Child is a Company Employee, the Spouse or Child's coverage under the Retiree Medical Benefit Program will be postponed until the Spouse or Child Terminates Employment with the Company.

3. Gap in Coverage. If there is a delay in a Former Employee's receipt of a Service Pension, then the Former Employee can elect temporary COBRA continuation coverage (see the COBRA section of the *Summary Plan Description for NTESS Health and Welfare Benefits Plan for Active Employees)* followed by enrollment in a Retiree Medical Benefit Program.

4. Termination of Coverage for Retiree. Retiree Medical Benefit Program coverage terminates for a Retiree and all his/her Dependents if the Retiree dies, or if Retiree Medical Benefit Program coverage terminates for the Retiree for any other reason. If the Retiree's Medical Benefit Program coverage terminates for non-payment

of premium, the Retiree and/or Dependents will need to wait until the next Post-Employment Open Enrollment or until there is a Mid-Year Change in Status Event (see, Appendix J) to re-enroll in the Retiree Benefit Package. Below are additional examples of events that cause coverage to terminate:

(i) Active Employment. If a Retiree returns to active on roll Employee status with the Company, the Retiree and his/her Dependents must be disenrolled from the Post-Employment Health & Welfare Benefits Plan. See, Section 4 and Section 5 for more information (including the possibility of future reinstatement of coverage).

(ii) Failure to Timely Enroll in Medicare. If a Retiree is eligible for and fails to timely enroll in a Company-Sponsored Medicare Benefit Program, then all Company-Sponsored Medical Benefit Program coverage for the Retiree and his/her Dependents will end. See, Section 4 for more information (including the possibility of future reinstatement of coverage).

(iii) Standard Reasons. See, also the standard reasons for termination of Plan coverage listed in Section 4.

5. Termination of Coverage for Dependent. Below are examples of when Retiree Medical coverage terminates for a Retiree's Spouse or Child:

(i) Retiree Coverage. If coverage terminates for the Retiree, then coverage ends for the Retiree's Spouse and Child, if any.

(ii) Dependent Status. If a Child ages out or otherwise ceases to be treated as a dependent Child under the Benefit Program, then coverage ends for the Child.

(iii) Divorce/Legal Separation. The Retiree's Spouse will lose coverage in the event of a divorce or legal separation from the Retiree.

(iv) Failure to Timely Enroll in Medicare. If the Spouse or Child is eligible for and fails to timely enroll in a Company-Sponsored Medicare Benefit Program, then coverage ends for the Spouse or Child, as the case may be. See, Section 4 for more information (including the possibility of future reinstatement of coverage).

(v) Active Employment. If a Retiree's Spouse/Child is an active Company Employee or returns to active on roll Employee status with the Company, then the Spouse/Child must be disenrolled from the Post-Employment Health & Welfare Benefits Plan. See, Section 4 for more information (including the possibility of future reinstatement of coverage).

(vi) Standard Reasons. See, also the standard reasons for termination of Plan coverage listed in Section 4.

6. Other Coverage.

(i) Surviving Spouse Benefit Package. Upon the Retiree's death, the Retiree's enrolled Surviving Spouse and enrolled Surviving Children may be eligible for the Surviving Spouse Benefit Package described later in this Section.

(ii) COBRA. COBRA continuation coverage for the enrolled Surviving Spouse and enrolled Surviving Children also may be available. See, Section 13.

(iii) Former Company Employee. If the Surviving Spouse is a Former Employee of the Company, who is eligible for Post-Employment Health and Welfare Benefits in his/her own right, the Surviving Spouse **must notify** the Post-Employment TPA so the Surviving Spouse can be moved to his/her own Retiree Benefit Package along with any Surviving Children.

B. LTD Terminee Benefit Package

Below is information regarding eligibility for LTD Terminee Medical Benefit Program coverage under the Plan's LTD Terminee Benefit Package.

1. Eligibility of Former Employee. A Former Employee becomes eligible for the LTD Terminee Benefit Package when the Former Employee has (i) Terminated Employment, and (ii) begun to receive long term disability benefit payments from a Company-Sponsored plan ("LTD Plan"). As soon as a Former Employee becomes eligible for the LTD Terminee Benefit Package, the Former Employee should contact the Post-Employment TPA to facilitate enrollment.

2. Eligibility of Dependents. LTD Terminee Medical Benefit Program coverage is available to the Spouse and/or the Children of the LTD Terminee. New Dependents (e.g., an LTD Terminee's new Spouse or new Child) can be added during the annual Post-Employment Open Enrollment or due to a Mid-Year Change in Status Event (see, Appendix J). If, however, the Spouse or Child is a Company Employee, the Spouse or Child's coverage under the LTD Terminee Medical Benefit Program will be postponed until the Spouse or Child Terminates Employment with the Company.

3. Gap in Coverage. If the Former Employee has a Termination of Employment before beginning to receive long term disability benefit payments, then the Former Employee can elect temporary COBRA continuation coverage (see the COBRA section of the *Summary Plan Description for NTESS Health and Welfare Benefits Plan for Active Employees)* followed by enrollment in an LTD Terminee Medical Benefit Program.

4. Termination of Coverage for LTD Terminee. LTD Terminee Medical Benefit Program coverage terminates for an LTD Terminee and all his/her Dependents if the LTD Terminee dies, recovers from a covered disability, or receives a lump sum payment from the LTD Plan. If the LTD Terminee's Medical Benefit Program coverage terminates for non-payment of premium, the LTD Terminee and/or Dependents will need to wait until the next Post-Employment Open Enrollment or until there is a Mid-Year Change in Status Event (see, Appendix J) to re-enroll in the LTD Benefit Package. Below are additional examples of events that cause coverage to terminate:

(i) Pre-Medicare Only. Some LTD Terminees are eligible only for Pre-Medicare coverage. As a consequence, Medical Benefit Program coverage will end for the LTD Terminee and his/her Dependents when the LTD Terminee becomes eligible for Medicare. See, the Eligibility Chart in Section 6.

(ii) Failure to Timely Enroll in Medicare. If an LTD Terminee is eligible for and fails to timely enroll in a Company-Sponsored Medicare Benefit Program,

then all Company-Sponsored Medical Benefit Program coverage for the LTD Terminee and his/her Dependents will end. See, Section 4 for more information (including the possibility of future reinstatement of coverage).

(iii) Standard Reasons. See, also the standard reasons for termination of Plan coverage listed in Section 4.

5. Termination of Coverage for Dependent. Below are examples of when LTD Terminee Medical Benefit Program coverage terminates for an LTD Terminee's Spouse or Child:

(i) LTD Terminee Coverage. If coverage terminates for the LTD Terminee, then coverage ends for the LTD Terminee's Spouse and Child, if any.

(ii) Divorce/Legal Separation. The LTD Terminee's Spouse will lose coverage in the event of a divorce or legal separation from the LTD Terminee.

(iii) Dependent Status. If a Child ages out or otherwise ceases to be treated as a dependent Child under the Benefit Program, then coverage ends for the Child.

(iv) Pre-Medicare Only. Some Dependents are eligible only for Pre-Medicare coverage. As a consequence, Medical Benefit Program coverage will end for the Dependent when the Dependent becomes eligible for Medicare. See, the Eligibility Chart in Section 6.

(v) Failure to Timely Enroll in Medicare. If the Spouse or Child is eligible for and fails to timely enroll in a Company-Sponsored Medicare Benefit Program, then coverage ends for the Spouse or Child, as the case may be. See, Section 4 for more information (including the possibility of future reinstatement of coverage).

(vi) Active Employment. If a Retiree's Spouse/Child is an active Company Employee or returns to active on roll Employee status with the Company, then the Spouse/Child must be disenrolled from the Post-Employment Health & Welfare Benefits Plan.

(vii) Standard Reasons. See, also the standard reasons for termination of Plan coverage listed in Section 4.

6. Other Coverage. COBRA continuation coverage for the enrolled Spouse and Children may be available. See, Section 13.

C. Surviving Spouse Benefit Package

Below is information regarding eligibility for Surviving Spouse Medical Benefit Program coverage under the Plan's Surviving Spouse Benefit Package.

1. Eligibility of Surviving Spouse.

(i) Active Employee Dies. The Surviving Spouse of an active Regular Company Employee is eligible for a Surviving Spouse Benefit Package, provided the Employee and the Surviving Spouse were enrolled in a Company-Sponsored Medical Benefit Program on the date of the Employee's death, or

(ii) Retiree Dies. The Surviving Spouse of a Retiree (as defined in Section 2.A.1 above) who is enrolled in a Company-Sponsored Medical Benefit Program pursuant to the Plan's Retiree Benefit Package is eligible for the Surviving Spouse Benefit Package; provided the Surviving Spouse was enrolled in as a Dependent of such a Retiree) on the date of that Retiree's death, or

(iii) Dual Sandians Both in Retiree Medical Package: When Dual Sandians both have satisfied the eligibility requirements in Section 2.A.1 for a Retiree Benefit Package but Dual Sandian #1 is covered as a dependent spouse under the Retiree Benefit Package of Dual Sandian #2, when Dual Sandia #1 dies, Dual Sandian #2 can become a Primary Covered Member in his or her own right. See, also Section 2.A.6 (Other Coverage), or

(iv) Dual Sandians Both Enrolled in Active Employee Medical Plan: In this scenario Dual Sandian #1 is covered as an employee under a Company Sponsored Medical Benefit program for active employees. Dual Sandian #2 is covered as a Dependent of Dual Sandian #1, and could have been enrolled in the Retiree Medical Benefit package. If Dual Sandian #2 dies, Dual Sandian #1 is eligible for Postponed Coverage for Active Employees within the meaning of Section (vi) below.

(v) Dual Sandians with Split Company-Sponsored Coverage: In this scenario Dual Sandian #1 is covered as a Retiree under the Retiree Medical Benefit package and Dual Sandian #2 is covered under a Company-Sponsored Medical Benefit Program for Active Employees. If Dual Sandian #1 dies, then Dual Sandian #2 is eligible for Postponed Coverage for Active Employees within the meaning of Section (vi) below.

(vi) Postponed Coverage for Active Employees: If a Surviving Spouse described in item (iv) above is an active Company Employee, Surviving Spouse Benefit Package coverage for the Surviving Spouse (and any Surviving Children) will be postponed until the Surviving Spouse Terminates Employment with the Company. Similarly, if a Surviving Child is a Company Employee, coverage otherwise available to the Surviving Child under the Surviving Spouse Benefit Package will be postponed for the Surviving Child until the Surviving Child has a Termination of Employment.

2. Eligibility of Surviving Children. Surviving Spouse Benefit Package coverage includes coverage for Surviving Children of a deceased Former Employee provided the Surviving Child was enrolled in a Company-Sponsored Medical Benefit Program on the date of death of the Former Employee. No new Children can be covered under a Surviving Spouse Benefit Package except Children born or adopted with respect to a pregnancy or placement for adoption that occurred before the Former Employee's death.

3. Termination of Coverage for Surviving Spouse. Surviving Spouse Benefit Package coverage ends for the Surviving Spouse and all Surviving Children and will not be reinstated if the Surviving Spouse remarries, dies, or if Surviving Spouse Medical Benefit Program coverage ceases for any other reason. For example:

(i) Continuous Coverage. Except for "Postponed Coverage for Active Employees" described above, the Surviving Spouse must be continuously enrolled in Surviving Spouse Medical Benefit Program coverage in order to retain Medical Benefit Program coverage. If the Surviving Spouse does not maintain continuous enrollment in a Medical Benefit Program, then coverage under the Medical Benefit Program will end (and will not be reinstated) for the Surviving Spouse and for all Surviving Children.

(ii) Pre-Medicare Only. Some Surviving Spouses are eligible only for Pre-Medicare coverage. As a consequence, Medical Benefit Program coverage will end (and will not be reinstated) for the Surviving Spouse and his/her Surviving Children when the Surviving Spouse becomes eligible for Medicare. (See, the Eligibility Chart in Section 6).

(iii) Failure to Timely Enroll in Medicare. If a Surviving Spouse is eligible for and fails to timely enroll in a Company-Sponsored Medicare Benefit Program, all Company-Sponsored Medical Benefit Program coverage for the Surviving Spouse and his/her Surviving Children will end and will not be reinstated. See, Section 4.

(iv) Standard Reasons. See, also the standard reasons for termination of Plan coverage listed in Section 4.

4. Termination of Coverage for Surviving Child. Surviving Spouse Benefit Package coverage ends for a Surviving Child when the Surviving Child dies, or if Surviving Spouse Medical Benefit Program coverage ends for the Child for any other reason. For example:

(i) Surviving Spouse Coverage. When coverage terminates for the Surviving Spouse, coverage under the Surviving Spouse Benefit Package terminates for all Surviving Children.

(ii) Continuous Coverage. Except for "Postponed Coverage for Active Employees" described above, the Surviving Child must be continuously enrolled in Surviving Spouse Medical Benefit Program in order to retain Medical Benefit Program coverage. If the Surviving Child does not maintain continuous enrollment in a Medical Benefit Program, then Medical Benefit Program coverage will end (and will not be reinstated) for the Surviving Child.

(iii) Pre-Medicare Only. Some Surviving Children are eligible only for Pre-Medicare coverage. As a consequence, Medical Benefit Program coverage will end for the Surviving Child if the Surviving Child becomes eligible for Medicare. (See, the Eligibility Chart in Section 6).

(iv) Failure to Timely Enroll in Medicare. If a Surviving Child is eligible for and fails to timely enroll in a Company-Sponsored Medicare Benefit Program, all Company-Sponsored Medical Benefit Program coverage for the Surviving Child will end (and will not be reinstated). See, Section 4.

(v) Dependent Status. Child ages out or otherwise ceases to be treated as a dependent Child under the Benefit Program.

(vi) Standard Reasons. See, also the standard reasons for termination of Plan coverage listed in Section 4.

3. Eligibility for Post-Employment Dental Care Benefit Program Coverage

A. Retiree Benefit Package

1. General Rules.

(i) Retiree Election. While a Participant in a Retiree Benefit Package is eligible (see, Section 2) for Company-Sponsored Medical Benefit Program coverage (Pre-Medicare and/or Medicare), that Participant can elect, during Post-Employment Open Enrollment or on account of a Mid-Year Change in Status (see, Appendix J) to receive only Medical Benefit Program coverage, only Dental Care Benefit Program coverage, or a combination of Medical Benefit Program and Dental Care Benefit Program coverage.

(ii) Retiree Coverage. If the Retiree ceases to be eligible for any Company-Sponsored Medical Benefit Program coverage (see, Section 2), then all Medical Benefit Program and Dental Care Benefit Program coverage will end for the Retiree and for the Retiree's Dependents. See, Section 4 for more information (including the possibility of future reinstatement of coverage).

(iii) No Cost Dental. If a Retiree otherwise would be eligible for Medical Benefit Program coverage (i.e., the Retiree has the option to enroll) and the Retiree waives Medical Benefit Program coverage for the Retiree and all his/her Dependents, then the Retiree and all his/her eligible Dependents can receive Dental Care Benefit Program coverage at no cost ("No Cost Dental").

(iv) Duration of No Cost Dental for Retiree. No Cost Dental generally will continue for the Retiree until the earlier of the date the Retiree enrolls in Retiree Medical Benefit Program coverage or the date the Retiree loses eligibility (i.e., the Retiree loses the option to enroll) in Retiree Medical Benefit Program coverage. See, Section 2 and Section 4 of this Summary Plan Description for additional information regarding loss of eligibility for Retiree Medical Benefit Program coverage.

(v) Duration of No Cost Dental for Dependents. No Cost Dental generally will continue for the Dependent (Spouse or Child) of a Retiree until the earlier of the date the Retiree loses eligibility for No Cost Dental, or the date the Dependent would have lost eligibility for (i.e., lost the option to be enrolled in) Retiree Medical Benefit Program coverage if the Retiree had not waived Retiree Medical Benefit Program coverage. For example, a Dependent Child's eligibility for No Cost Dental will be lost if the Child ages out of Dependent status, a Dependent Spouse's eligibility for No Cost Dental will be lost if the Retiree and the Spouse are divorced, and eligibility of a Dependent (Spouse or Child) for No Cost Dental will be lost if the Dependent becomes an active on roll Company Employee. See, Section 2 and Section 4 of this Summary Plan Description for additional information regarding loss of eligibility for Retiree Medical Benefit Program coverage.

2. Additional Requirements for Dependent Coverage.

(i) Retiree Coverage. Dental Care Benefit Program coverage or Medical Benefit Program coverage is not available to the Dependent of a Retiree unless the Retiree actually is enrolled (not just eligible to enroll) in Dental Care Benefit Program coverage or Medical Benefit Program coverage, as the case may be.

(ii) Loss of Coverage. If the Dependent (Spouse or Child) of a Retiree ceases to be eligible for any Company-Sponsored Medical Benefit Program coverage (see, Section 2), then all Medical Benefit Program and Dental Care Benefit Program coverage will end for that Dependent.

(iii) No Cost Dental. See item A.1(v), above for information regarding duration of No Cost Dental for Dependents of a Retiree.

B. LTD Terminee Benefit Package

1. Dental Care Benefit Program. Effective January 1, 2023, Participants in an LTD Terminee Benefit Package became eligible for Dental Care Benefit Program coverage.

2. General Rules.

(i) LTD Terminee Election. While a Participant in an LTD Terminee Benefit Package is eligible (see, Section 2) for Company-Sponsored Medical Benefit Program coverage (Pre-Medicare or Medicare), that Participant can elect, during Post-Employment Open Enrollment or on account of a Mid-Year Change in Status (see, Appendix J) to receive only Medical Benefit Program coverage, only Dental Care Benefit Program coverage, or a combination of Medical Benefit Program and Dental Care Benefit Program coverage.

(ii) LTD Terminee Coverage. If the LTD Terminee ceases to be eligible for any Company-Sponsored Medical Benefit Program coverage (see, Section 2), then all Medical Benefit Program and Dental Care Benefit Program coverage will end for the LTD Terminee and for the LTD Terminee's Dependents. See, Section 4 for more information (including the possibility of future reinstatement of coverage).

(iii) No Cost Dental. If an LTD Terminee otherwise would be eligible for Medical Benefit Program coverage (i.e., the LTD Terminee has the option to enroll) and the LTD Terminee waives Medical Benefit Program coverage for the LTD Terminee and all his/her Dependents, then the LTD Terminee and all his/her eligible Dependents can receive Dental Care Benefit Program coverage at no cost ("No Cost Dental").

(iv) Duration of No Cost Dental for LTD Terminee. No cost Dental generally will continue for the LTD Terminee until the earlier of the date the LTD Terminee enrolls in LTD Terminee Medical Benefit Program coverage or the date the LTD Terminee loses eligibility (i.e., the LTD Terminee loses the option to enroll) in LTD Terminee Medical Benefit Program coverage. See, Section 2 and

Section 4 of this Summary Plan Description for additional information regarding loss of eligibility for LTD Terminee Medical Benefit Program coverage.

(v) Duration of No Cost Dental for Dependents. No Cost Dental generally will continue for the Dependent (Spouse or Child) of an LTD Terminee until the earlier of the date the LTD Terminee loses eligibility for No Cost Dental, or the date the Dependent would have lost eligibility for (i.e., lost the option to be enrolled in) LTD Terminee Medical Benefit Program coverage if the LTD Terminee had not waived LTD Medical Benefit Program coverage. For example, a Dependent Child's eligibility for No Cost Dental will be lost if the Child ages out of Dependent status, a Dependent Spouse's eligibility for No Cost Dental will be lost if the LTD Terminee and the Spouse are divorced, and eligibility of a Dependent (Spouse or Child) for No Cost Dental will be lost if the Dependent becomes an active on roll Company Employee. See, Section 2 and Section 4 of this Summary Plan Description for additional information regarding loss of eligibility for LTD Terminee Medical Benefit Program coverage.

3. Additional Requirements for Dependent Coverage.

(i) LTD Terminee Covered. Dental Care Benefit Program coverage or Medical Benefit Program coverage, as the case may be, is not available to the Dependent of an LTD Terminee unless the LTD Terminee actually is enrolled (not just eligible to enroll) in Dental Care Benefit Program coverage or Medical Benefit Program coverage.

(ii) Loss of Coverage. If the Dependent (Spouse or Child) of an LTD Terminee ceases to be eligible for any Company-Sponsored Medical Benefit Program coverage (see, Section 2), then all Medical Benefit Program and Dental Care Benefit Program coverage will end for that Dependent.

Note: If the Dependent was receiving "No Cost Dental" (see, item B.1(iii) above), the Dependent's loss of Company-Sponsored Medical Benefit Program coverage will not cause the LTD Terminee to lose Dental Care Benefit Program coverage.

Surviving Spouse Benefit Package. Effective January 1, 2023, Surviving Spouses became eligible for Dental Care Benefit Program coverage.

1. General Rules.

(i) Initial Eligibility:

a. Surviving Spouse. If, on the day before the death of his/her deceased Spouse (Retiree/Active Employee), the Surviving Spouse was covered under a Company-Sponsored (active or post-employment) Dental Care Benefit Program then, when the Surviving Spouse first becomes eligible ("Initial Eligibility Date") to participate in a Surviving Spouse Benefit Package (see, Section 2), the Surviving Spouse can elect Dental Care Benefit Program coverage (for the Surviving Spouse).

b. Surviving Child. If a Surviving Child was covered under a Company-Sponsored (active or post-employment) Dental Care Benefit Program on the day before the death of the deceased Spouse

(Retiree/Active Employee), then on the Initial Eligibility Date, a Surviving Spouse who elects Dental Care Benefit Program coverage for him/herself also can elect Dental Care Benefit Program coverage for that Surviving Child. If Dental Care Benefit Program coverage for the Surviving Spouse or for a Surviving Child is not properly elected during the Initial Eligibility Date, then Dental Care Benefit Program coverage cannot be added at a later date.

(ii) Additional Requirement**.** Dental Care Benefit Program coverage is not available to a Surviving Spouse or Surviving Child unless the Surviving Spouse or Surviving Child, as the case may be, is actually enrolled (not just eligible to enroll) in a Company-Sponsored Medical Benefit Program.

(iii) Ongoing Eligibility**.** The Surviving Spouse can elect to drop (but not to add) Dental Care Benefit Program and/or Medical Benefit Program coverage for him/herself or for a Surviving Child.

Caution:

If Dental Care Benefit Program coverage is lost/dropped for a Surviving Child, it *cannot be reinstated*.

If Dental Care Benefit Program coverage is lost/dropped for the Surviving Spouse, it will be lost/dropped, for the Surviving Spouse and for his/her Surviving Children and *cannot be reinstated*.

If Medical Benefit Program coverage is lost/dropped for a Surviving Child, then Dental Care Benefit Program coverage automatically will be lost/dropped for that Surviving Child and *cannot be reinstated.*

If, for any reason (see, Section 2), Medical Benefit Program coverage for the Surviving Spouse is lost/dropped, then all Surviving Spouse Benefit Package coverage will end for the Surviving Spouse and for his/her Surviving Children and Surviving Spouse Benefit Package coverage *cannot be reinstated.*

4. Enrollment and Duration of Coverage

This Section describes enrollment procedures and outlines when Plan coverage ends. See, Section 2 and Section 5 for additional information.

A. Enrollment in a Pre-Medicare Benefit Program.

The following individuals, who may be eligible for Post-Employment Benefit Package coverage, will need to contact the Post-Employment TPA in order to initiate enrollment in post-employment Medical and Dental Care Benefit Programs.

(i) Retiree. A Former Employee who is eligible for but does not start his/her Service Pension immediately upon Termination of Employment must contact the Post-Employment TPA upon commencing pension payments to enroll in a Retiree Benefit Package.

(ii) LTD Terminee. A disabled Former Employee who has Terminated Employment must contact the Post-Employment TPA when he/she begins receiving long term disability benefit payments from a Company-Sponsored plan in order to enroll in an LTD Terminee Benefit Package.

(iii) Surviving Spouse. A Surviving Spouse who qualifies for participation in a Surviving Spouse Benefit Package (see, Section 2) must contact the Post-Employment TPA upon the death of his/her Spouse, to coordinate enrollment in a Surviving Spouse Benefit Package.

B. Enrollment in a Medicare Benefit Program.

In order to enroll in a Company-Sponsored Medicare Benefit Program (see, Section 6), an otherwise eligible Primary Covered Member or Dependent must have coverage under Medicare. See, Appendix I (Medicare) for additional information.

We recommend that an individual (Former Employee or Dependent) who is covered by a Benefit Package (see, Section 2), and who is eligible for Company-Sponsored Medicare Benefit Program coverage (see, Section 6), contact Medicare to begin the Medicare Part A and Part B enrollment process no later than 90 days before the individual's anticipated Medicare Start Date (see definition below). At the same time, the individual (referred to below as a "Benefit Package Participant") should contact the Post-Employment TPA (see, Appendix H for contact information) to initiate enrollment in a Medicare Medical Benefit Program (see, Section 6).

An individual's **Medicare Start Date** is the first day of the month the individual attains age 65, or the first day of the month prior to the month the individual attains age 65 if the individual's birthday falls on the first day of a month.

If an individual is disabled, his/her Medicare Start Date can be an earlier date based on the individual's date of disability as determined by Social Security Administration.

The Post-Employment TPA will facilitate coordination of Medicare Part A and Medicare Part B coverage with the Benefit Package Participant's enrollment in a Medicare Advantage or Medicare Supplement (Medigap) plan (see, Appendix I).

> If the Plan incurs extra costs because a Benefit Package Participant fails to timely enroll in Medicare Part A, Medicare Part B, or in a Company-Sponsored Medicare Benefit Program, the Company reserves the right to retroactively terminate all Company-Sponsored Medical Benefit Program coverage and to collect these extra costs from the Primary Covered Member.

C. Lapse in Coverage.

1. Primary Covered Member. If the Benefit Package Participant is the Primary Covered Member (e.g., the Retiree, the LTD Terminee, or the Surviving Spouse) and there is a lapse in Coverage (e.g., the Primary Covered Member fails to timely enroll in a Company-Sponsored Medicare Benefit Program or to timely pay Premiums), then all Medical Benefit Program coverage for the Primary Covered Member and his/her covered Dependents will end.

If the Primary Covered Member is a Retiree or an LTD Terminee, then Medical Benefit Program coverage may be reinstated at the next Post-Employment Open Enrollment or on account of a Mid-Year Change in Status Event (see, Appendix J).

If the Primary Covered Member is the Surviving Spouse, then Medical Benefit Program coverage under the Surviving Spouse Benefit Package will end for the Surviving Spouse and all Surviving Children and that coverage will not be reinstated.

2. Dependent. If the Benefit Package Participant is the Dependent (e.g., Spouse, Child, or Surviving Child) of a Primary Covered Member and the Dependent fails to timely enroll in Medicare or to timely pay Premiums) then all Medical Benefit Program coverage for the Dependent, will end.

If the Dependent (e.g. Spouse or Child) is participating in a Retiree Benefit Package or an LTD Terminee Benefit Package, then coverage for the Dependent can be reinstated at the next Post-Employment Open Enrollment or on account of a Mid-Year Change in Status Event (see, Appendix J).

For a Surviving Child who is participating in a Surviving Spouse Benefit Package, Medical Benefit Program coverage for that Surviving Child under the Surviving Spouse Benefit Package will end and will not be reinstated.

D. When Coverage Ends

1. Plan coverage for the Primary Covered Member generally ends on:

(i) the last day of the month in which the Primary Covered Member has paid the required premium (see, Section 10),

(ii) the last day of the month in which the Primary Covered Member ceases to be eligible for coverage,

(iii) the date of death of the Primary Covered Member,

(iv) the last day of the month for which the Primary Covered Member has paid for coverage,

(v) immediately upon determination of the submission of a fraudulent claim,

(vi) the date the Plan, Benefit Package, or Benefit Program terminates, and/or as further described in this Summary Plan Description and in the applicable Benefit Program material referenced in Appendix B, whichever occurs first.

2. Plan coverage for a Dependent (Spouse or Child) of a Primary Covered Member generally ends on:

- the last day of the month in which the Dependent ceases to be eligible for coverage,
- the last day of the month in which coverage for the Primary Covered Member ends,
- the last day of the month for which the Primary Covered Member has paid for coverage,
- the last day of the month in which the Primary Covered Member has paid the required premium (see, Section 10),
- the last day of the month of the death of the Primary Covered Member,
- immediately upon determination of the submission of a fraudulent claim,
- the date of the Dependent's death, and/or as further described in this Summary Plan Description and in the applicable Benefit Program material referenced in Appendix B, whichever occurs first.

E. Healthcare Reimbursement Account (HRA)

Coverage ends on the last day of the month in which coverage ends under the Company-Sponsored Total Health Benefit Program (see, Section 6). The Primary Covered Member may submit claims for up to 90 days following the last day of coverage under the Company's Total Health Benefit Program. All dates of service must fall between the beginning of the Plan Year and the last day of coverage under the Company's Total Health Benefit Program. Balances remaining in the account will be forfeited after that. Continuation under COBRA may be an option. Contact the HRA carrier (see, Appendix A Directory of Benefit Programs) for details and instructions.

F. Continuation Coverage

When Plan coverage ends, continuation coverage may be available. See, Section 13 for additional information.

5. General Eligibility Requirements

Outlined below are general eligibility requirements for Plan coverage. These general eligibility requirements are in addition to the Benefit Package eligibility requirements outlined in Section 2, the Dental Care Benefit Program eligibility requirements outlined in Section 3, and the Enrollment provisions outlined in Section 4.

A. Coverage for Family Members

Generally, Family Member(s) are eligible only for the Benefit Program(s) in which the Primary Covered Member is enrolled; provided the Family Member satisfies all other requirements for coverage. See, also the discussion of "Split Coverage" in Section 6.

1. No Duplicate Coverage. Family Members of Company Employees may not have double coverage under Company-Sponsored benefits. For example, if one parent is covered under the NTESS Post-Employment Health and Welfare Benefits Plan and the other parent is covered under the NTESS Health and Welfare Benefits Plan for Active Employees, the parents must choose which parent will cover the Child for benefits. The Child cannot be covered under both parents' medical and dental benefit programs. The Plan reserves the right to collect reimbursement for any Plan benefits provided due to duplicate enrollment.

2. Post-Employment Medical and Dental Coverage. An active Employee of the Company may not be enrolled in medical or dental coverage under the NTESS Post-Employment Health and Welfare Benefits Plan ("Post-Employment Plan") as a Dependent, as a Surviving Spouse/Surviving Child, or in any other capacity. Please see examples below, and the Rehired Retirees Chart in Appendix K for additional information.

Examples:

(i) Active Employee Spouse. While you and your Spouse are both active eligible Employees, your Spouse is covered as a Dependent under your active Employee medical and/or dental coverage. When you Terminate Employment and enroll in medical and/or dental coverage under the Post-Employment Plan, your active Employee Spouse must enroll in active Employee medical and/or dental coverage as the Primary Covered Member if your active Employee Spouse wishes to maintain medical and/or dental Benefit Program coverage. Your active-Employee Spouse cannot be a Dependent under Post-Employment Plan medical and/or dental coverage until your active-Employee Spouse ceases to be an active Employee. Your active-Employee Spouse can cover you as a Dependent as long as you are not enrolled in the Post-Employment Plan.

(ii) You are Rehired. If you were receiving Company-Sponsored medical and/or dental coverage under the Post-Employment Plan, and you are rehired as an active Employee of the Company (or a member of the Company's controlled group of companies), you will be disenrolled from Post-Employment Plan medical and dental coverage and, if you are eligible, you can participate in medical and/or dental coverage offered to active Company Employees.

B. Qualified Medical Child Support Orders

The Plan honors Qualified Medical Child Support Orders (QMCSOs). A QMCSO is a judgment, decree, or order, including a court-approved settlement agreement, that:

- is issued by
  - a domestic relations court or other court of competent jurisdiction; or
  - through an administrative process established under state law which has the force and effect of law in that state.
- assigns to a child the right to receive health benefits for which the child of a participant is eligible under the Plan; and
- the Plan Administrator determines is qualified under the terms of ERISA and applicable state law.

You can get a copy of the Plan's QMCSO procedures upon written request to HR Solutions at no cost to you.

In general, only children who meet the eligibility requirements as Dependents under the Plan – for example, by meeting the age requirements – can be covered under a QMCSO.

C. Misuse of Plan

The Company reserves the right to disenroll individuals and their Family Members who misuse the Plan. Misuse of the Plan includes, but is not limited to, falsifying enrollment or claims information, allowing ineligible individuals to use Plan identification cards, and abusive behavior towards Plan providers or representatives.

Insurance companies may have their own rules that apply to misuse of an insured Benefit Program in which you are enrolled. If the insurer's rules conflict with Plan rules, the insurer's rules will govern.

Failing to comply with Plan eligibility requirements may constitute fraud or intentional misrepresentation of a material fact that can trigger retroactive termination (rescission) of Plan coverage for all Family Members, in which case all Family Members could become liable for benefits already paid on behalf of ineligible persons.

D. Documentation

To confirm eligibility of Family Members, the Company, the Insurance Companies, and third-party administrators may request documentation to verify the relationship, including but not limited to birth certificates, adoption records, marriage certificates, proof of adult Dependent eligibility and tax documentation.

In addition, the Company may request information regarding Medicare eligibility and enrollment, Family Member eligibility, address information, and more. Participants are required to promptly provide the requested information within the time frame specified by the Company.

The Company reserves the right to disenroll all Family Members if a Family Member fails to timely provide documentation when requested. *See, e.g., the above paragraph regarding rescission on account of "Misuse of Plan."*

E. Loss of Eligibility

Whenever a Family Member loses eligibility to participate in a Company-Sponsored Benefit Program (e.g., a Child attains age 26, a Spouse is divorced, a Participant who is not eligible for Company-Sponsored Medicare benefits becomes eligible for Medicare), it is the responsibility of the Primary Covered Member to disenroll that Family Member from the Benefit Program no later than 31 calendar days after the loss of eligibility. Participants can disenroll a Family Member by contacting the Post-Employment TPA (see, Appendix H for contact information). *If the Primary Covered Member fails to disenroll a Family Member who loses eligibility, the Company reserves the right to collect from the Primary Covered Member any excess Company costs and Benefit Program expenses incurred by the ineligible Family Member. See, also, the above paragraph regarding rescission on account of "Misuse of Plan."*

F. Failure to Make Required Participant Contributions

If Participants do not timely pay required Participant contributions or premiums for benefits under the Plan, coverage for all Family Members may be terminated irrevocably (and retroactively), and the Company reserves the right to take any and all action to recover costs for terminated coverage. Under these circumstances, the Company also may commence legal action to recover amounts owed to the Plan. See, also, Section 10.

G. Appendix K

See Appendix K for the definition of, and eligibility and other provisions governing "Service Pension Rehires" and "Post-May 2022 Rehires"

6. Post-Employment Medical and Dental Benefit Programs

Pre-Medicare and Medicare Medical Benefit Programs described in Paragraph A and Paragraph B, and the Dental Care Benefit Program described in Paragraph C below currently are available to Participants in a Benefit Package described in Section 2 of this SPD.

Note: Previously, only Participants in a Retiree Benefit Package were eligible for the Dental Care Benefit Program. Effective January 1, 2023, a Surviving Spouse (with respect to a Surviving Spouse Benefit Package) or an LTD Terminee (with respect to an LTD Terminee Benefit Package) became eligible to elect participation in the Dental Care Benefit Program on behalf of all Participants covered under his/her Benefit Package. See, Section 3.

As outlined in Paragraph D, and the Chart at the end of this Section, some Participants are eligible only for Pre-Medicare Medical Benefit Programs, while other Participants are eligible for the Pre-Medicare and the Medicare Medical Benefit Programs.

A. Pre-Medicare Medical Benefit Programs.

The Plan offers the Medical Benefit Programs described below to eligible individuals (see Paragraph D and the Chart at the end of this Section) who are not Medicare Eligible. Please see the Benefit Program Materials listed in Appendix B for additional information about these Benefit Programs.

1. Total Health Medical Benefit Programs. These are "**PPO Programs**" (i.e., they provide a more cost-effective benefit if a Participant receives services from a provider in the PPO Network). Three Company-Sponsored Total Health PPOs are offered (administered by UnitedHealthcare (UHC), Blue Cross Blue Shield of New Mexico (BCBSNM), and Kaiser Permanente of Northern California (Kaiser)), with generally the same plan design and contributions; however, the Kaiser-administered program is limited to individuals residing in Northern California. The Company-Sponsored Total Health Benefit Programs include prescription drug coverage.

2. Health Reimbursement Account ("HRA"). The Company pairs its **Total Health Medical Benefit Programs** (see, item 1 immediately above) with a Health Reimbursement Account ("HRA"). An HRA is automatically funded solely by Company contributions. See, Post-Employment Open Enrollment materials for annual funding allocations. Dollars contributed to an HRA generally must be used by the Participant only for eligible healthcare expenses (see, e.g., Internal Revenue Code Section 213(d)). Funds in the HRA carry over for use in the next year, up to the maximum allowed balance.

Please contact the Post-Employment TPA for information regarding a limited ability for individuals enrolled in a Pre-Medicare Benefit Program to transfer HRA funds credited to an HRA while the individual was an active Company Employee to this Pre-Medicare HRA.

If, when an HRA Participant becomes Medicare eligible, the Participant does not have a Pre-Medicare Spouse or Child who is eligible to use HRA funds, the Participant's HRA funds will be forfeited.

3. High Deductible Health Plan Benefit Programs. These Benefit Programs operate similarly to the **PPO Programs** described above. However, with a High Deductible Health Plan Benefit Program, you pay a lower premium in exchange for a higher deductible for most services. Two High Deductible Health Plan Benefit Programs are offered (administered by UnitedHealthcare (UHC) or by Blue Cross Blue Shield of New Mexico (BCBSNM)). The Company-Sponsored High Deductible Health Plans include prescription drug coverage.

B. Medicare Medical Benefit Programs.

The Plan offers the Medical Benefit Programs described below to eligible individuals (see Paragraph D, and the Chart at the end of this Section) who are Medicare Eligible (e.g., age 65 or older, or eligible for Medicare as a result of disability). In order to participate in the Medicare Medical Benefit Programs listed in item 1 and item 2 below, an individual **MUST BE enrolled in and paying premiums (if required) for Medicare Part A and Medicare Part B.**

> Note: You cannot enroll in a Company-Sponsored Medicare Advantage Benefit Program (item 1, below) and also elect the YSA Benefit Program (item 2, below). It is an either/or choice, not both.

1. Company-Sponsored Medicare Advantage Benefit Program. The Company-Sponsored Medicare Advantage Plans are health plan options (like an HMO or a PPO) approved by Medicare and sold by private companies. Company-Sponsored Medicare Advantage Plans provide Medicare health coverage (including Part A-hospital insurance and Part B-medical insurance) and, in addition, Medicare drug coverage. Participants who enroll in one of these Plans must assign their Medicare benefits to the Medicare Advantage Plan.

The Company offers the following Company-Sponsored Medicare Advantage Plans to eligible Participants who Terminated Employment before January 1, 2012:

(i) Humana Group Medicare Advantage HMO Plan (limited to certain counties in New Mexico)

(ii) UnitedHealthcare Group Medicare Advantage PPO Plan

(iii) Kaiser Senior Advantage Group HMO (limited to Northern California)

See the Medicare overview in Appendix I (including the Table at the end of Appendix I) and the most recent Benefit Program Materials (e.g., Evidence of Coverage and Post-Employment Open Enrollment materials) listed in Appendix B for more information (e.g., covered Service Areas, associated benefits, and Medicare Advantage Plan rules). Reminder: Medicare benefits are governed by the Medicare statute and regulations.

Note: If you are enrolled in the Company-Sponsored Medicare Advantage Plan, and you subsequently enroll in a non-Company-Sponsored Medicare Advantage Plan or a Medicare Part D Plan (see, discussion in Appendix I), you will be disenrolled from the Company-Sponsored Medicare Advantage Plan because Medicare does not allow dual enrollment. If you are a Retiree or an LTD Terminee, and you would like to return to the Company-Sponsored Medicare Advantage Plan, you must wait until the next Post-Employment Open Enrollment period. If you are a Surviving Spouse and you are disenrolled, you and your Surviving Children will lose all Surviving Spouse Benefit Package Medical and Dental Benefit Program coverage, and that coverage will not be reinstated. See, e.g., Surviving Spouse Benefit Package descriptions in Section 2 and Section 3.

2. YSA Benefit Program. The YSA Benefit Program provides annual "credits," which can be used to buy individual Medicare plans (e.g., Medigap Plans, Part D (Prescription Drug) Plans, and Medicare Advantage Plans) through an Exchange established by the Post-Employment TPA. A Table at the end of Appendix I outlines differences between/among these individual Medicare plans.

YSA "credits" also may be used to reimburse Medicare Part A or Part B premiums, and/or to pay for certain out of pocket medical or Dental Care expenses. The Post-Employment TPA can provide you with information regarding individual Medicare plans and premium rates available in your area. See, also Appendix B and the applicable Benefit Program Materials (e.g., Post-Employment Open Enrollment materials and Benefit Summaries) for additional information, including calculation of "credits."

If you are eligible for the YSA Benefit Program, you must enroll in a Medicare Plan through the Post-Employment TPA. If you enroll directly through the carrier, you will not be eligible for the YSA Credits. Reminder: Medicare benefits are governed by the Medicare statute and regulations.

C. Dental Care Benefit Program.

The Dental Care Benefit Program is a PPO program (i.e., a higher level of benefit is available if the Participant receives services from a provider in the Network). The Dental Care Benefit Program offers diagnostic, preventive, and restorative services, including limited orthodontic services. Delta Dental is the Dental Care Benefit Program administrator. See, Section 3 for more information.

D. Split Coverage

When a Retiree or an LTD Terminee and his/her Dependents (Children and/or Spouse), or a Surviving Spouse and his/her Surviving Children are enrolled in medical coverage, and both Pre-Medicare and Medicare benefits are available (see Chart at the end of this Section), there may be "split coverage." For example:

If the Retiree (or LTD Terminee) and Dependents are enrolled in a Pre-Medicare Medical Benefit Program and the Retiree (or LTD Terminee) becomes Medicare eligible, then the Retiree (or LTD Terminee) will be offered only the Medicare Benefit Programs outlined in Paragraph B, above, while his/her Pre-Medicare Dependents will be offered only the Pre-Medicare Benefits outlined in Paragraph A, above.

Similarly, if the Surviving Spouse and Surviving Children are enrolled in a Pre-Medicare Medical Benefit Program, and the Surviving Spouse becomes Medicare eligible, then the Surviving Spouse will be offered only the Medicare Benefit Programs outlined in Paragraph B, above, while the Pre-Medicare Children will be offered only the Pre-Medicare Benefits outlined in Paragraph A, above (unless the Child also is Medicare eligible).

E. Eligibility Chart

The Chart below shows how hire/rehire dates determine eligibility to receive Pre-Medicare Medical benefits (described in Paragraph A, above), Medicare Medical benefits (described in Paragraph B, above), and Dental Care benefits (described in Paragraph C, above).

Section 2 of this Summary Plan Description contains additional information about each of the Benefit Packages referenced in this Chart.

Hire/Rehire Date **Rehire Includes rehire by Parent Organization**	**Retiree Benefit Package**	**LTD Terminee Benefit Package**	**Surviving Spouse Benefit Package**
Non-Represented Employee hired/rehired prior to 1/1/2009	Pre-Medicare, Medicare and Dental	Pre-Medicare, Medicare and Dental	Pre-Medicare, Medicare and Dental (No YSA coverage is provided if the Surviving Spouse Benefit Package is available on account of the death of an active Employee who, on his/her date of death, had fewer than 15 Years of Service.)

Hire/Rehire Date **Rehire Includes rehire by Parent Organization**	**Retiree Benefit Package**	**LTD Terminee Benefit Package**	**Surviving Spouse Benefit Package**
OPEIU-Represented Employee hired/rehired prior to 1/1/2009	Pre-Medicare, Medicare and Dental	Pre-Medicare, Medicare and Dental	Pre-Medicare, Medicare and Dental (No YSA coverage is provided if the Surviving Spouse Benefit Package is available on account of the death of an active Employee who, on his/her date of death, had fewer than15 Years of Service.)
MTC- SPA-Represented Employee hired/rehired prior to 7/1/2010	Pre-Medicare, Medicare and Dental	Pre-Medicare, Medicare and Dental	Pre-Medicare, Medicare and Dental (No YSA coverage is provided if the Surviving Spouse Benefit Package is available on account of the death of an active Employee who, on his/her date of death, had fewer than 15 Years of Service.)
Non-Represented Employee hired/rehired on or after 1/1/2009	No Medical or Dental coverage - Access Only Plan was discontinued as of 1/1/2023.	Pre-Medicare & Dental only (Medical & Dental end upon Medicare eligibility.)	Pre-Medicare & Dental only (Medical & Dental end upon Medicare eligibility.)

Hire/Rehire Date **Rehire Includes rehire by Parent Organization**	**Retiree Benefit Package**	**LTD Terminee Benefit Package**	**Surviving Spouse Benefit Package**
OPEIU-Represented Employee hired/rehired on or after 1/1/2009	No Medical or Dental coverage - Access Only Plan was discontinued as of 1/1/2023.	Pre-Medicare & Dental only (Medical & Dental end upon Medicare eligibility.)	Pre-Medicare & Dental only (Medical & Dental end upon Medicare eligibility.)
MTC- SPA-Represented Employee hired/rehired on or after 7/1/2010	No Medical or Dental coverage - Access Only Plan was discontinued as of 1/1/2023.	Pre-Medicare & Dental only (Medical & Dental end upon Medicare eligibility.)	Pre-Medicare & Dental only (Medical & Dental end upon Medicare eligibility.)

7. Additional Information Regarding Health Benefit Programs

A. Provider Networks

After coverage takes effect, Participants who are enrolled in a Benefit Program (see, Section 6) that offers benefits through provider networks can contact the Benefit Program to request a list of providers or visit the Benefit Program administrator's website. For a list of Benefit Program administrators, please see Appendix A.

If a Participant is enrolled in a Company-Sponsored Medicare Advantage Plan, the Participant can find a list of providers on the Medicare Advantage Plan's website or call the Medicare Advantage Plan directly and the carrier will mail you a printed version of the provider listing.

Participants also can obtain provider directories by viewing the Benefit Program vendor's website (see, Appendix A), by contacting the appropriate Benefit Program customer service number listed in Appendix A, or by contacting the Post-Employment TPA.

If, pursuant to the YSA Benefit Program (see, Section 6), a Participant enrolls in a Medicare Supplement Plan, the Participant must see providers who accept Medicare assignment. No network is required.

B. Benefit Program Materials

Benefit Program material listed in Appendix B also contain information about the following:

1. How to use network providers,

2. The composition of the network,

3. The circumstances under which coverage will be provided for out-of-network services, and

4. Conditions or limits on the selection of primary care providers or specialty medical providers.

C. Lifetime Maximums

The Company's post-employment Pre-Medicare Medical Benefit Programs (see, Section 6) do not have lifetime dollar maximums except for Infertility and Travel and Lodging Benefits. Please refer to the NTESS medical carrier benefit summaries for more information.

The Company's post-employment Dental Benefit Program has a $1,800 per person lifetime orthodontic maximum. Please refer to the NTESS dental benefit summary for more information.

D. Maternity Hospital Stays (Newborns' and Mothers' Health Protection Act)

Federal law protects the benefit rights of mothers and newborns related to hospital stays in connection with childbirth. In general, group health programs and health insurance issuers may not:

1. Restrict benefits for the length of hospital stay for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does allow the mother's or newborn's attending provider, after consulting with the mother, to discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

2. Require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay of up to 48 hours (or 96 hours as applicable).

Benefit Program materials in Appendix B contain additional information about state laws that may apply to maternity coverage offered pursuant to the Plan's Medical Benefit Programs. Reminder: Medicare benefits are governed by the Medicare statute and regulations.

E. Benefits for Mastectomy-Related Services (Women's Health and Cancer Rights Act)

Company-Sponsored Medical Benefit Programs will not restrict benefits if the Primary Covered Member or his/her Dependents:

- receive benefits for a mastectomy, and
- elect breast reconstruction in connection with the mastectomy.

Benefits will not be restricted provided the breast reconstruction is performed in a manner determined in consultation with the patient's physician and shall include:

- all stages of reconstruction of the breast on which the mastectomy was performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Benefits for breast reconstruction will be subject to annual deductibles and co-insurance amounts consistent with benefits for other covered services under the Benefit Program.

Benefit Program materials in Appendix B contain additional information about state laws that may apply to mastectomy-related coverage offered pursuant to the Plan's Medical Benefit Programs. Reminder: Medicare benefits are governed by the Medicare statute and regulations.

F. Pre-existing Condition Limitations

Except as provided below with respect to Medicare Supplement Plans (see, Appendix I), when an individual enrolls in one of the Company's post-employment Medical Benefit Programs or the Company's post-employment Dental Care Benefit Program, the individual will not be excluded from enrollment based on health, nor will the individual's premium or level of benefits be based on any pre-existing condition limitations.

A Participant must enroll in an individual Medicare Supplement Plan through the YSA Benefit Program, **within 63 days from the loss of his/her Company-Sponsored**

group coverage. If the Participant enrolls within the 63-day window after loss of coverage, the Participant will not be denied coverage or pay more for coverage. If the Participant waits to enroll until after the 63-day window, the Participant can be declined coverage or be charged more for coverage based on his/her health history.

If a Participant is enrolled in an individual Medicare Supplement Plan through the YSA Benefit Program and wants to upgrade his/her Medicare Supplement Plan coverage (e.g., from Plan G to Plan N), individual carriers have the right to underwrite on past health experience, and most do, so the Participant may not be able to upgrade coverage. In addition, if a Participant wants to change carriers, the Participant also may be subject to underwriting.

G. Descriptions of Covered Services

1. Benefit Program Material. The Benefit Program materials listed in Appendix B describe covered services provided by Medical and Dental Benefit Programs, including, but not limited to:

(i) coverage of drugs, emergency care, preventive care, medical tests and procedures, hospitalization and durable medical equipment,

(ii) eligibility to receive services,

(iii) exclusions, limitations, and terms for obtaining coverage (such as rules regarding preauthorization and utilization review),

(iv) cost sharing (including premiums, deductibles, co-insurance, and co-payment amounts),

(v) annual and lifetime maximums and other caps or limits,

(vi) circumstances under which services may be denied, reduced, or forfeited,

(vii) procedures, including preauthorization and utilization review, to be followed in obtaining services,

(viii) procedures available for the review of denied claims,

(ix) how to use network providers,

(x) composition of the network,

(xi) circumstances under which coverage will be provided for out-of-network services, and

(xii) conditions or limits on the selection of primary care providers or specialty medical providers.

2. Availability. Benefit Program Material for the Medical or Dental Care Benefit Program in which a Participant is enrolled generally will be available to the Participant. Participants who do not receive this material should contact the Post-Employment TPA. Participants also may obtain benefit information for a Benefit Program in which they are enrolled by contacting the Benefit Program directly at the address or phone number listed in Appendix A.

8. Retiree Life Insurance Benefit Program

This Section describes post-employment life insurance coverage provided to certain grandfathered Retirees. Since these are grandfathered benefits, when determining eligibility*, it is necessary to review the list of "Excluded Groups" at the end of this Section.*

Although this life insurance currently is provided at no cost to the Retiree, the value of this life insurance in excess of $50,000 will result in imputed income taxable to the Retiree.

When used in this Section, the term "Dependent Parent" and "Dependent Child" are as determined by the insurance company.

Please see, Appendix G (Glossary) for definitions of additional terms used in this Section, including "Plan Sponsor," "Retire," "Retiree," "Termination of Employment," and "Annual Base Pay."

See, also, Appendix K (Rehired Retirees) for the impact on Retiree Life Insurance of a Retiree's return to work for the Company or a Parent Organization.

GRANDFATHERED LIFE INSURANCE BENEFITS FOR FORMER EMPLOYEES

Retirees who are described below and who are not in an Excluded Group (see below) receive, currently at no cost, the following Group Term Life Insurance coverage:

1. Pre-2007 Retirees. Basic Life Insurance for Former Employees who Retired from the Plan Sponsor with a Service Pension before 2007, and who are not in an Excluded Group receive the following Basic Life Insurance Benefits:

(i) Basic Group Term Life. Basic Group Term Life Insurance coverage equal to 100% of Annual Base Pay on the day before the Former Employee Retires, or $500 to the Retiree's estate if a qualified family member (i.e., Dependent Parent, Dependent Child, Spouse married to Retiree on date of death and for at least 1 year) does not survive Retiree.

(ii) Basic Supplemental Group Term Life. Basic Supplemental Group Term Life Insurance coverage equal to 100% of Annual Base Pay on the day before the Former Employee Retires. When the Retiree turns age 66, the value of his/her Basic Supplemental Group Term Life Insurance Coverage reduces by 10% per year for the next five (5) years. When the Retiree reaches age 70, coverage is continued at 50% of Annual Base Pay.

2. 2007 and 2008 Retirees. Former Employees who Retired from the Plan Sponsor with a Service Pension in 2007 or 2008, and who are not in an Excluded Group receive Primary Group Term Life Insurance equal to 100% of Annual Base Pay on the day before the Former Employee Retired. When the Retiree turns age 66, the value of this coverage reduces by 10% per year for the next five (5) years. When the Retiree reaches age 70, coverage is continued at 50% of Annual Base Pay.

3. Post-2008 Retirees. Former Employees who Retired from the Plan Sponsor with a Service Pension after December 31, 2008, and who are not in an Excluded Group receive Post-2008 Primary Group Term Life Insurance equal to the

lesser of 100% of Annual Base Pay on the day before the Former Employee Retires, or $50,000. When the Retiree turns age 66, the value of his/her Post-2008 Primary Group Term Life Insurance Coverage reduces by 10% per year for the next five (5) years. When the Retiree reaches age 70, coverage is continued at 50% of Annual Base Pay.

EXCLUDED GROUPS

Former Employees who are described in the list below are not eligible for Retiree Life Insurance provided by the Plan Sponsor.

1. A Former Employee of the Plan Sponsor who is not classified as a Retiree (see, Appendix G ("Glossary") for definition) when the Former Employee incurs a Termination of Employment with the Plan Sponsor.

2. A Former Employee who is re-hired; provided, however, that an individual who is re-hired as a part-time temporary employee (also known as a Service Pension Rehire) on or after September 2, 2022, can retain their current Retiree Life Insurance, if any.

3. A Surviving Spouse of a Former Employee of the Plan Sponsor.

Note: This provision does not exclude a Surviving Spouse who also is a Former Employee in their own right from otherwise qualifying to receive Retiree Life Insurance pursuant to standard Plan provisions.

4. Non-represented Former Employees who incur a Termination of Employment on or after January 1, 2019.

5. SPA- or OPEIU-represented Former Employees who incur a Termination of Employment on or after January 1, 2020.

6. MTC-represented Former Employees who incur a Termination of Employment on or after January 1, 2021.

9. Primary Group Term Life Insurance Benefit Program for Long Term Disability Terminees

This Section describes post-employment life insurance coverage provided to Long Term Disability Terminees ("LTD Terminees"). For a discussion of Retiree Life Insurance, please see, Section 8.

Although this life insurance currently is provided at no cost to the LTD Terminee, the value of this life insurance in excess of $50,000 will result in imputed income taxable to the LTD Terminee.

For purposes of this Section, "Total Disability" is as determined by the Long-Term Disability insurance carrier, and "Net Credited Service" is based on the LTD Terminee's Years of Service.

Please see, Appendix G (Glossary) for definitions of additional terms used in this Section, including "Long Term Disability Terminee," "Termination of Employment," "Termination Date," and "Annual Base Pay."

PRIMARY GROUP TERM LIFE INSURANCE

Subject to the Eligibility Requirements outlined below, an LTD Terminee receives Primary Group Term Life Insurance equal to Annual Base Pay on the day before his/her Termination Date. When the LTD Terminee turns age 66, the value of Primary Group Term Life Insurance Coverage reduces by 10% per year for the next five (5) years. When the LTD Terminee reaches age 70, coverage is continued at 50% of Annual Base Pay.

ELIGIBILITY

An LTD Terminee's eligibility for Primary Group Term Life Insurance is based on Net Credited Service, as provided in the table below.

Net Credited Service upon Termination of Employment on Account of Total Disability	Extension of Coverage after Termination of Employment on Account of Total Disability
Less than 5 years	1-year extension
5 years but less than 10 years	2-year extension
10 years or more	3-year extension

For additional information, please contact **HR Solutions** at 505-284-4700.

10. Premiums

This Section explains how Medical and Dental Care Benefit Program premiums are determined for a Retiree, LTD Terminee who Terminated Employment before January 1, 2012, and for the Surviving Spouse of an active Employee who died before January 1, 2012.

Premiums are in addition to applicable deductibles, co-payments, out-of-network charges, and non-covered items.

Premiums paid by Participants for Medical and Dental Care Benefit Programs are paid on an after-tax basis. The Company-paid portion of a Medical or Dental Care Benefit Program premium generally is not taxable income to the Participant.

By participating (accepting coverage) in Company-Sponsored Benefit Packages and Benefit Programs, Primary Covered Members agree to pay their share of the cost of coverage. This agreement applies to coverage the Primary Covered Member affirmatively elects, and to coverage the Primary Covered Member and his/her Dependents receive in the absence of an affirmative election (e.g., automatic continuation of prior coverage).

The Primary Covered Member is required to notify the Post-Employment TPA if the Primary Covered Member or his/her covered Dependent becomes eligible for Medicare Primary Coverage.

If the Primary Covered Member or his/her covered Dependent is eligible for primary coverage under Medicare (even if not enrolled in Medicare), and he/she receives primary coverage under a Company-Sponsored Pre-Medicare Benefit Program (see, Section 6), the Primary Covered Member will be responsible for reimbursing the Company for the excess coverage provided by the Company-Sponsored Pre-Medicare Benefit Program

OVERVIEW

For Pre-Medicare Participants, projected costs and contributions are reviewed each Plan Year, and are subject to change. Plan costs and contributions changes are effective each January 1.

For Medicare Participants, the Centers for Medicare and Medicaid (CMS) regulate premiums for Medicare products, including the Company-Sponsored Medicare Advantage Benefit Programs. These premium changes are effective each January 1.

Actual Medical and Dental Care Benefit Program premiums for a given Plan Year are communicated during the Plan's annual Post-Employment Open Enrollment, which is held each fall prior to the start of the Plan Year. Primary Covered Members can contact the Post-Employment TPA for premium-share information. This information is also included in the Plan's post-employment Post-Employment Open Enrollment materials.

Billing and Premium Statements

When a Primary Covered Member (a Retiree, LTD Terminee, or a Surviving Spouse) is enrolled in a Benefit Package (see, Section 2 for a discussion of Benefit Packages), the

Primary Covered Member will receive Medical and/or Dental Care Benefit Program premium billing statements from the Post-Employment TPA. This information will include the applicable premium (s), as adjusted (if applicable) for any NTESS Premium Share.

The Post-Employment TPA mails out premium billing statements for Medical and Dental Care Benefit Programs (see, Section 6 for a discussion of Benefit Programs) between the 10th and 15th of each month for the upcoming month. Primary Covered Members have until the end of the upcoming month to pay the applicable premium(s).

Example: The billing statement for February should arrive in mid-January. If the Primary Covered Member does not remit payment to the Post-Employment TPA by the end of February, the Primary Covered Member and his/her Dependents may experience a lapse in coverage (see, consequences below).

With every premium billing statement, the Post-Employment TPA includes a form for use in electing to have premiums automatically deducted from the Participant's bank account via electronic funds transfer (EFT). Participants can elect this feature at any time by following the directions provided with the form. It may take several months to set up the EFT. In the meantime, if a Participant receives a premium billing statement, payment should be remitted timely. Once EFT is in place, Participants will cease to receive monthly premium billing statements. Similarly, Participants who elect to pay in advance for a month or two will not receive a premium billing statement for the pre-paid month(s).

Note: If there is an insignificant (as determined by the Company) cost increase or decrease for a Medical or Dental Care Benefit Program during the year, and it causes a corresponding change in premium-share amount, the Company automatically will increase or decrease Participant premiums on a prospective basis to reflect the change. If the mid-year change in coverage results in premiums being owed by the Primary Covered Member, the Post-Employment TPA will bill the Primary Covered Member for the amount(s) owed.

Lapse in Coverage

The Company provides Participants a 60-day grace period after a payment is due. After this date there will be a lapse in coverage.

For Participants enrolled in the Retiree Benefit Package or the LTD Terminee Benefit Package, a lapse in coverage means that the Participant (and the Participant's eligible Dependents) must **wait until the Plan's next annual Post-Employment Open Enrollment to re-enroll (unless there is an applicable Mid-Year Change in Status Event (see, Appendix J).**

For Participants enrolled in the Surviving Spouse Benefit Package, a lapse in coverage means that **coverage under that Benefit Package will be terminated and will not be reinstated for the Surviving Spouse and their Dependents.**

Premium Share

The summaries below outline premium share for Participants in a Retiree, an LTD Terminee, or a Surviving Spouse Benefit Package (see, Section 2). When the term "Dependent" is used below, it does not include a Class II Dependent.

RETIREE BENEFIT PACKAGE – PREMIUM SHARE

Retiree Group #1: Retiree and covered Dependents of Retiree if Retiree Terminated Employment:

- *Between August 8, 1977, and January 1, 1988, at age 64 or older, with at least 10 years of service as of age 65; or*
- *Before January 1, 1988, with at least 15 years of service; or*
- *Between January 1, 1988, and December 31, 1994, with a service or disability pension*

Pre-Medicare Premium Share:

The Company currently pays the full cost, except for Retirees who currently pay for a portion of the medical coverage

Company-Sponsored Medicare Advantage Plan Premium Share

The Company pays the full cost

YSA Credit (if applicable and elected; see, Glossary and Section 3)

Receives the full YSA Credit

Dental Care Premium Share

The Company pays the full cost

Retiree Group #2: Retiree and covered Dependents of Retiree, if Retiree Terminated Employment with a Service or Disability pension *after December 31, 1994, and before January 1, 2003*

Pre-Medicare Premium Share:

Retiree pays 10% of the full experience-rated premium

Company-Sponsored Medicare Advantage Plan Premium Share

Retiree pays 10% of the full premium

YSA Credit (if applicable and elected; see, Glossary and Section 3)

90% of the full YSA Credit

Dental Care Premium Share

The Company pays the full cost

Retiree Group #3: Retiree and covered Dependents of Retiree, if Retiree Terminated Employment with a Service or Disability pension *after December 31, 2002, and prior to January 1, 2012*

Pre-Medicare Premium Share

Retiree pays a percentage of full experience-rated premium based on Retiree's Years of Service (see, table below)

Years of Service	Retiree Premium Share %
30+ years	10%
25-29 years	15%
20-24 years	25%
15-19 years	35%
10-14 years	45%

Company-Sponsored Medicare Advantage Plan Premium Share

Retiree pays a percentage of premium based on Retiree's Years of Service (see, table above).

YSA Credit (if applicable and elected; see, Glossary and Section 3)

A percentage of full YSA Credit based on Retiree's Years of Service. See most current Post-Employment Open Enrollment materials for more information.

Dental Care Premium Share

- Employees who Retired prior to January 1, 2009, do not pay a premium share
- Employees who were hired or rehired prior to January 1, 2009, but Retired after January 1, 2009, pay a monthly premium. Rates are based on Retiree, Retiree plus one or Retiree plus two or more.

LTD TERMINEE BENEFIT PACKAGE- - PREMIUM SHARE

LTD Terminee Group #1: LTD Terminee and covered Dependents of LTD Terminee, if LTD Terminee:

- *Became an LTD Terminee prior to January 1, 2003; or*
- *Retired with a Disability Pension after December 31, 1994, and prior to January 1, 2003*
- *Receiving a Company-Sponsored LTD Benefit Payment*

Pre-Medicare Premium Share:

LTD Terminee pays 10% of the full experience-rated premium

Company-Sponsored Medicare Advantage Plan Premium Share

LTD Terminee pays 10% of the full premium

YSA Credit (if applicable and elected; see, Glossary and Section 3)

90% of the full YSA Credit

Dental Care Premium Share

The Company pays the full cost

LTD Terminee Group #2: LTD Terminee and covered Dependents of LTD Terminee, if LTD Terminee became an LTD Terminee *after December 31, 2002, and before January 1, 2012, and is included in one of the following groups*:

- a non-represented employee who was hired or rehired prior to January 1, 2009; or
- an OPEIU-represented employee who was hired or rehired prior to July 1, 2009; or
- an MTC- or SPA-represented employee who was hired or rehired prior to July 1, 2010
- Receiving a Company-Sponsored LTD Benefit Payment

Pre-Medicare Premium Share:

LTD Terminee pays 35% of the full experience-rated premium

Company-Sponsored Medicare Advantage Plan Premium Share

LTD Terminee pays 35% of the full premium

YSA Credit (if applicable and elected; see, Glossary and Section 3)

65% of the full YSA Credit

Dental Care Premium Share

- Except as noted below, LTD Terminee pays the full experience-rated premium
- LTD Terminees who Terminated Employment prior to January 1, 2009, do not pay a premium share
- LTD Terminees who were hired or rehired prior to January 1, 2009, but Terminated Employment after January 1, 2009, pay a monthly premium of 20% of the full experience-rated premium. Rates are based on LTD Terminee, LTD Terminee plus one or LTD Terminee plus two or more.

SURVIVING SPOUSE BENEFIT PACKAGE- - PREMIUM SHARE

Surviving Spouse Group #1: Surviving Spouse and Surviving Children of an *active Regular Employee* with *15 or more Years of Service; provided the active Regular Employee was included in one of the groups listed below:*

- *a non-represented employee who was hired or rehired prior to January 1, 2009; or*
- *an OPEIU-represented employee who was hired or rehired prior to July 1, 2009; or*
- *an MTC- or SPA-represented employee who was hired or rehired prior to* July 1, 2010

Pre-Medicare Premium Share:

Surviving Spouse pays 50% of the full experience-rated premium

Company-Sponsored Medicare Advantage Plan Premium Share

Surviving Spouse pays 50% of the full premium

YSA Credit (if applicable and elected; see, Glossary and Section 3)

50% of the full YSA Credit

Dental Care Premium Share

Surviving Spouses of Retirees with more than 15 years of service who Retired prior to January 1, 2012, pay 50% of the monthly premium for dental coverage.

Surviving Spouses of Retirees with less than 15 years of service pay the full monthly premium for the dental coverage.

Rates are based on Surviving Spouse, Surviving Spouse +one or Surviving Spouse plus two or more.

Surviving Spouse Group #2: Surviving Spouse and Surviving Children of a Retiree, if Retiree Terminated Employment *with a Service Pension or Disability Pension on or before December 31, 2011*

Pre-Medicare Premium Share:

Surviving Spouse pays 50% of the full experience-rated premium

Company-Sponsored Medicare Advantage Plan Premium Share

Surviving Spouse pays 50% of the full premium

YSA Credit (if applicable and elected; see, Glossary and Section 3)

50% of the full YSA Credit

Dental Care Premium Share

Surviving Spouses of Retirees with more than 15 Years of Service who Retired prior to January 1, 2012, pay 50% of the monthly premium for dental care coverage.

Surviving Spouses of Retirees with less than 15 Years of Service pay the full monthly premium for the dental care coverage.

Rates are based on Surviving Spouse, Surviving Spouse +one or Surviving Spouse plus two or more.

Class II Dependents: A small, "grandfathered" group of Children of Retirees.

Pre-Medicare Premium Share:

Class II Dependents enrolled prior to 1987 are included in the premium share Retirees pay for themselves and their Class I (regular) Dependents.

Class II Dependents enrolled after 1986 pay 70% of the full experience-rated premium.

Company-Sponsored Medicare Advantage Plan Premium Share

Class II Dependents are not eligible for the Medicare Advantage Plan

YSA Credit (if applicable and elected; see, Glossary and Section 3)

Class II Dependents are not eligible for the YSA Credit or the YSA Benefit Program

Dental Care Premium Share

The Company pays the full cost

11. Making Changes to Your Elections

In general, the Benefit Programs and coverage levels Primary Covered Members choose when newly eligible or at annual Post-Employment Open Enrollment remain in effect through the end of the Plan Year. Primary Covered Members may be able to change these elections if certain events occur, as further explained in Appendix J: Summary of Permitted Mid-Year Changes.

Primary Covered Members must contact the Post-Employment TPA no later than 31 calendar days (60 calendar days for Medicaid/CHIP events and upon the birth or adoption of a child) after the date of the event to request a change. Otherwise, the next opportunity to enroll a Spouse or a new Dependent, or to make other Benefit Program changes generally is the next annual Post-Employment Open Enrollment period or, if earlier, the date of a qualified Mid-Year Change in Status Event, as described in Appendix J.

Annual Post-Employment Open Enrollment

To the extent provided in Section 2, Section 3, Section 4 and Section 5 of this Summary Plan Description, and in Appendix J, a Primary Covered Member may enroll for coverage, change coverage or opt out of participation during Post-Employment Open Enrollment. Certain Benefit Programs may not be open to new enrollees each year.

Post-Employment Open Enrollment elections are effective January 1 of the following year.

Certain individuals with COBRA Continuation Coverage also may be eligible to participate in the annual Post-Employment Open Enrollment process for their covered Benefit Programs if the coverage has not terminated.

12. Claims and Appeals Procedures

If a Participant has questions or concerns about Plan benefits and/or eligibility to participate in a Benefit Program, the Participant is encouraged to communicate with the Post-Employment TPA (see, Appendix H for contact information) and the Post-Employment TPA will put the Participant in contact with the appropriate Claims Administrator for the Benefit Program about which the Participant is concerned (see, also, Appendix C for a list of "Claims Administrators."). The appropriate Claims Administrator will provide Participants with its standard Claims and Appeals Procedures.

See the following Appendices for examples of "standard" Claims and Appeals Procedures:

Appendix D for "Eligibility Claims and Appeals Procedures"

Appendix E for "Medical and Dental Care Benefit Program Claims and Appeals Procedures"

Appendix F for "Life Insurance Benefit Program Claims and Appeals Procedures"

A claim or appeal must be made directly to the applicable Claims Administrator, and in accordance with the actual claims and appeals procedures, followed by that Claims Administrator. For example, some Claims Administrators may offer more than one level of appeal.

A claim must be filed within **180 calendar days from the date the claim was incurred**, or as provided in the claims and appeals procedures followed by the applicable Claims Administrator (**which may require the claim to be filed earlier**).

Unless specifically provided otherwise in the applicable insurance policy or administrative agreement, no action at law or in equity in any court or agency may be brought with respect to the Plan, Benefit Packages, and/or Benefit Programs under the Plan prior to exhaustion of the applicable claims and appeals procedures, nor may an action be brought at all **unless it is brought within 180 calendar days after the date the applicable Claims Administrator (or Independent Review Organization, as the case may be) renders its final decision upon appeal.**

The claims and appeals procedures for each Benefit Program will be furnished upon request, without charge. A Participant who has not received a copy of these procedures should contact the Post-Employment TPA.

13. Health Care Continuation

A. Federal COBRA

Under a Federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985 as amended), a temporary extension of health coverage (called "continuation coverage") at group rates may be available when there is a loss of coverage under a Retiree Benefit Package, an LTD Terminee Benefit Package, or a Surviving Spouse Benefit Package. See, Section 2 of this SPD.

This Section describes COBRA continuation coverage available to individuals actively participating in the above-referenced post-employment Benefit Packages.[2]

At the end of this Section, there is a brief discussion of other (perhaps less expensive) continuation coverage that may be available when an individual becomes eligible for COBRA coverage.

The Company has delegated COBRA administration to a COBRA Vendor. Please see, Appendix A of this Summary Plan Description for the COBRA Vendor's contact information.

B. Applicable Benefit Programs

As of the date of this SPD, COBRA continuation coverage is available with respect to the following Company-Sponsored, post-employment Benefit Programs (each an "Applicable Benefit Program").

1. Total Health Medical Benefit Programs
2. Health Reimbursement Account ("HRA")
3. High Deductible Health Plan Benefit Programs
4. Company-Sponsored Medicare Advantage Benefit Program
5. Dental Care Benefit Program

Note: COBRA does not apply to individual Medicare plans offered through the YSA Benefit Program; however, dollar "credits" in the YSA may be subject to COBRA.

C. What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Applicable Benefit Program coverage when it would otherwise end because of a "Qualifying Event." Specific Qualifying Events are listed below.

After a Qualifying Event, COBRA continuation coverage is offered to each person who is a "Qualified Beneficiary." A Former Employee, the Former Employee's Spouse, and

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[2] *See the Summary Plan Description for the NTESS Health and Welfare Benefits Plan for Active Employees* for information about COBRA health care continuation coverage available when an *active* Employee and/or the Family Members of an *active* Employee lose healthcare coverage.

the Former Employee's Children can be Qualified Beneficiaries if coverage under an Applicable Benefit Program is lost because of a Qualifying Event.

Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Generally, the cost is 102% of the full group rate premium.

The Spouse of a Retiree or an LTD Terminee will become a Qualified Beneficiary if the Spouse loses Applicable Benefit Program coverage because of the following Qualifying Events:

1. Death of Retiree or LTD Terminee, or

2. Spouse becomes divorced or legally separated from Retiree or LTD Terminee.

Children of a Retiree, an LTD Terminee, or a Surviving Spouse will become Qualified Beneficiaries if they lose coverage under an Applicable Benefit Program because of the following Qualifying Events:

3. The Retiree, LTD Terminee, or Surviving Spouse dies,

4. The parents (Retiree or LTD Terminee and his/her Spouse) of the Child become divorced or legally separated, or

5. The Child loses eligibility for coverage as a dependent child under the generally applicable requirements of the Plan.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of Applicable Benefit Program coverage of any individual covered under the Plan, that individual can become a Qualified Beneficiary.

D. When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Post-Employment TPA has been notified that a Qualifying Event has occurred. The Company will notify the Post-Employment TPA of the following Qualifying Events:

1. Death of the Retiree, LTD Terminee, or Surviving Spouse; or

2. Commencement of a proceeding in bankruptcy with respect to the employer.

For all other Qualifying Events (divorce or legal separation or a Child's losing eligibility for coverage as a dependent child), the Primary Covered Member (Retiree, LTD Terminee, or Surviving Spouse) must notify the Post-Employment TPA (see, Appendix H for contact information) within 60 days after the Qualifying Event occurs.

E. How is COBRA Continuation Coverage Provided?

Once the Post-Employment TPA receives notice that a Qualifying Event has occurred, the Post-Employment TPA will notify the COBRA Vendor and continuation coverage will be offered to the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Former Employees

may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children.

F. Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage that lasts a maximum of 36 months.

COBRA continuation coverage may be terminated early for any of the following reasons: (i) the Company no longer provides the Applicable Benefit Program to any of its Former Employees, their Spouses, or their Children; (ii) the premium for continuation coverage is not paid in a timely manner; (iii) the Qualified Beneficiary, after electing COBRA continuation coverage, becomes covered under any other group health plan, as a covered employee or otherwise, which provides coverage that is substantially similar to the COBRA continuation coverage that Qualified Beneficiary was receiving (and does not contain any applicable exclusion or limitation with respect to any pre-existing condition); and/or (iv) for any reason (e.g., fraud) that the Plan would terminate coverage of a Former Employee or a Former Employee's Dependent who is not receiving COBRA coverage.

G. Are there Other Coverage Options Available Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Former Employees and their Family Members through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. For more information, see www.healthcare.gov.

For example, a Qualified Beneficiary may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Qualified Beneficiary may be eligible for lower costs on his/her monthly premiums and lower out-of-pocket costs. Additionally, a Qualified Beneficiary may qualify for a 30-day special enrollment period for another group health plan for which the Qualified Beneficiary is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

14. Coordination of Benefits

A. When You Have Other Coverage

The procedures and timeframes described in this Section are the general coordination of benefit rules applicable to the Company's health benefits.

If a Participant and his/her Dependents are enrolled in a Company-Sponsored health Benefit Program as well as another health program, such as a Benefit Program offered by the employer of the Participant's Spouse, the Company-Sponsored program coordinates its coverage with the other program. The Company-Sponsored program also coordinates its coverage with Medicare.

Here's how it works in general:

- When the Company-Sponsored program pays first, in other words, if the Company-Sponsored program is the "primary" program, it pays benefits as though no other program exists. The other program may or may not pay benefits.
- When the Company-Sponsored program pays second, in other words, if the Company-Sponsored program is the "secondary" program, it may or may not pay a benefit, depending on what the other program (the "primary" program) has paid. The most an enrolled person can receive is a combined total of 100% of eligible expenses from both programs.

B. Which Plan Pays First?

If a Participant and his/her covered Dependents are also covered under another health program, the first of the following rules which applies determines which program is primary:

1. A program without a coordination of benefits provision is considered primary.

2. A program that covers the person other than as a Dependent (for example, as an Employee) is primary. The program that covers the person as a Dependent (for example, as the Spouse of an Employee) is secondary.

However, this order of payment is reversed in certain cases when the person is a Medicare beneficiary. If (due to Federal law) Medicare is secondary to the plan covering the person as a Dependent, and Medicare is primary to the plan covering the person as a non-Dependent, then the plan covering the person as a non-Dependent (for example, a retiree) pays secondary and the other plan (for example, the plan of the retiree's working Spouse) pays primary.

3. For a Dependent child whose parents are married or are living together, whether or not they have ever been married, or if a court decree establishes joint custody of the child without specifying which parent is responsible to provide health coverage, the Company uses the "birthday rule" to determine which program pays benefits first when the child is covered under both parents' programs. Under the birthday rule, the program covering the parent whose birthday falls first in the calendar

year is primary. The program of the parent whose birthday falls later in the year is the secondary program.

If both parents share the same birthday, the primary program will be the program that has covered one parent the longest. The secondary program will be the program that has covered the other parent for a shorter period of time.

4. For a Dependent child whose parents are divorced or separated or are not living together, whether or not they were ever married, and the child is covered under both parents' programs, the birthday rule does not apply. Instead, the Company uses the following rules to determine which program pays benefits first:

- First, the program of the parent to whom the court specifically assigned financial responsibility for health care expenses (for instance, through a Qualified Medical Child Support Order),
- Then, the program of the parent who has custody,
- Then, the program of the Spouse married to the parent who has custody,
- Then, the program of the parent who does not have custody, and
- Finally, the program of the Spouse married to the parent who does not have custody.

5. A program in which a person is enrolled as an active Employee (or as that Employee's Dependent) rather than as a laid-off or retired Employee is primary.

6. In most cases, a program in which a person is enrolled as an active Employee or subscriber rather than as a COBRA participant is primary.

7. The program covering the person for the longest period of time is considered primary.

8. If none of the above rules determines which program is primary, the allowable expenses shall be shared equally between the programs.

C. Coordination of Benefits with Medicare

Be sure to tell your doctor and other providers if you have coverage in addition to Medicare. This will help them send your bills to the correct payer and can help avoid delays. If you have questions about who pays first, or if your insurance changes, call the Medicare Coordination of Benefits and Recovery Center 1-855-798-2627 (TTY/TDD: 1-855-797-2627).

Note: If a Participant who is eligible for Medicare or for primary coverage under another group health plan is provided primary coverage under a Company-Sponsored medical Benefit Program, the Participant will be responsible for reimbursing the Company for the coverage provided by the Company-Sponsored medical Benefit Program.

15. General Plan Provisions

A. Administration of Plan

The Plan Administrator has full discretionary authority to administer and interpret the Plan, including discretionary authority to determine eligibility for participation and for benefits under the Plan, to correct errors (to the extent practicable), and to construe ambiguous terms. The Plan Administrator may delegate its discretionary authority and such duties and responsibilities as it deems appropriate to facilitate day-to-day administration of the Plan and, unless the Plan Administrator provides to the contrary, such a delegation will carry with it the full discretionary authority to accomplish the delegation. Determinations by the Plan Administrator or the Plan Administrator's authorized delegate will be final and conclusive upon all persons.

B. Plan Amendment and Termination

The Company or its authorized delegate reserves the right in its sole discretion to amend in writing the Plan, or any Benefit Program or Benefit Package offered under the Plan, in whole or in part, or to completely or partially discontinue in writing the Plan or any Benefit Program at any time. The Company's decision to amend or terminate is not a fiduciary decision. It is a business decision that can be made solely in the Company's interest. No participant, Dependent or beneficiary has a vested right to any benefits under the Plan.

The Company or its authorized delegate may, in its sole discretion, in writing, at any time, discontinue or reduce the Company's contributions to the Plan, increase participant contributions, co-pays, deductibles or other participant costs related to the Plan, or implement any cost control measures that the Company, in its sole discretion, deems advisable.

C. Insured Benefits

Certain benefits under this Plan are fully insured. The Insurance Companies that provide insured benefits under the Plan have been delegated the full discretionary authority to administer those benefits. See, Appendix A for information on which Benefit Programs are insured.

With respect to insured benefits, claims for benefits are sent to the Insurance Company. In this case, the Insurance Company is responsible for paying claims, not the Company.

The Insurance Company is responsible for and has full discretionary authority for:

- Determining eligibility for and the amount of any benefits payable under the applicable Benefit Program.
- Prescribing claims and appeal procedures to be followed and claims and appeal forms to be used by plan participants pursuant to the applicable program.

The Insurance Company also has the authority to require plan participants to furnish information it deems necessary or appropriate for the proper administration of the applicable Benefit Program.

With respect to insured benefits, you (or, in the case of your death, your beneficiary as that term is defined in the applicable insurance policy or contract) will be entitled to receive only the insured benefit actually provided under the insurance policy or contract.

The Company does not assume or have any liability or responsibility for any insured benefit, and you will be able to look only to the insurance contracts for payment or any benefits. You will not have any claim for insured benefits against the Company, the Plan Administrator, or any Employee, officer, or director of the Company.

D. Contributions and Premiums

Please note that there is no separate fund or account that secures benefits under this Plan. In no event will the Company have any obligation to fund benefits provided under the Plan in advance of the date those benefits are payable or to pre-pay premiums or other fees required in order to provide insured benefits under the Plan. The Company's contribution, if any, may be paid directly to the Insurance Company or other provider under the Plan. Such payments shall constitute a complete discharge of the liability of the Benefit Program, the Company, the Plan Administrator, the Plan, and their authorized delegates.

E. No Right to Assets

No participant, Dependent, or beneficiary shall have any right to, interest in, or claim upon any particular assets of the Company, the Plan, any Benefit Program or any underlying contract, trust or other funding vehicle.

F. Acts of Third Parties

When a Participant or a covered Dependent ("You") are injured or become ill because of the action or inaction of a third party, the Plan may cover Your eligible health care (e.g., medical, prescription drug, dental and vision) expenses. However, to receive coverage, You must notify the Plan that Your illness or injury was caused by a third party, and You must follow special Plan rules. This Section describes the Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right (but not the obligation) to "step into the shoes" of the person who is injured or ill and to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this Section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to You by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, You agree that the Plan has rights of recovery, reimbursement and subrogation to the extent of any benefits paid for an illness or injury that is caused by a third party. You also agree that the Plan:

- Has a first priority equitable lien, including an equitable lien by contract, on any and all monies paid (or payable to) You or for Your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;

- May appoint You as constructive trustee for any and all monies paid (or payable to) You or for Your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
- May, in its discretion, bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If You (or Your attorney or other representative) receive any payment from the sources listed later in this Section — through a judgment, settlement or otherwise — for an illness or injury that is caused by a third party, You agree (i) to promptly notify the Plan Administrator, and (ii) to have the funds held in a separate, identifiable account by You or the holder of the funds and that the Plan has an equitable lien on the funds, and You agree to serve as a constructive trustee over the funds to the extent the Plan has paid expenses related to that illness or injury. This means that You will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation You receive from the responsible party, regardless of whether Your settlement or judgment says that the money You receive (all or part of it) is for health care expenses and regardless of any doctrines that may affect the Plan's right of recovery or reimbursement, including, but not limited to, the "make-whole doctrine."

You must pay the Plan back regardless of whether the third party admits liability and regardless of whether You have been made whole or fully compensated for Your injury. If any money is left over, You may keep it.

The Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) You incur in obtaining the funds. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that You, Your guardian or other representatives receive or are entitled to receive,
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that You, Your guardian or other representatives receive,
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid, and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to You, Your guardian, or other representatives.

As a Plan participant, You are required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary.
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of Your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Plan, the Claims Administrator, the Plan Administrator, or their authorized representatives.
- Execute and deliver such documents as may be required and do whatever else is needed to secure the Plan's rights.

The Plan may terminate Your Plan participation and/or offset Your future benefits for the value of benefits advanced, if You do not provide the information, authorizations, or otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If these subrogation provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If these right of recovery provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

All Plan rights under this Section remain enforceable against the heirs and estate of any covered person.

G. Mistake

No person is entitled to any benefit under the Plan or any Benefit Program except and to the extent expressly provided under the Plan or the Benefit Program. The fact that payments have been made from the Plan or Benefit Program in connection with any claim for benefits under the Plan or Benefit Program does not (a) establish the validity of the claim, (b) provide any right to have such benefits continue for any period of time, or (c) prevent the Plan or Benefit Program from recovering the benefits paid to the extent the Plan Administrator determines that there in fact was no right to payment of the benefits under the Plan or Benefit Program.

If the Plan Administrator determines that a Plan benefit should not have been paid to a person (whether or not attributable to an error by such person, the Plan Administrator or any other person), then the Plan Administrator or its delegate may take such action as it deems necessary or appropriate to remedy the situation, including without limitation, deducting the amount of any such overpayment from any succeeding payments to or on behalf of such person under the Plan or Benefit Program or from any amounts due or owing to such person by the Company or under any other plan, program or arrangement benefiting the Employees or former Employees of the Company, or otherwise recovering such overpayment from whoever has benefited from it.

If the Plan Administrator determines that an underpayment of benefits has been made, the Plan Administrator shall take such action as it deems necessary or appropriate to remedy such situation. In no event shall interest be paid on the amount of any underpayment.

H. Responsibility for Benefit Programs

Please note that:

- All service providers are independent contractors of the applicable program; neither the Company nor the Plan Administrator is responsible for their actions.
- Neither the Plan Administrator nor the Company is responsible for the fiscal viability of benefit providers or for the continuing participation of doctors, hospitals, and others in their networks.
- Neither the Plan Administrator nor the Company can warrant or guarantee the quality or the length of service of providers.

I. No Guarantee of Employment

The Plan does not give any individual the right to be employed by the Company or interfere with the Company's right to discharge any Plan participant at any time.

J. Assignment of Benefits

With respect to creditors and potential creditors (including but not limited to providers of services covered under the Plan), no Participant (or beneficiary of a Participant) may assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any amount payable to the Participant (or beneficiary) at any time under the Plan. Any attempt to so assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any such amount, whether presently or thereafter payable will be void. If a Participant or beneficiary of a Participant attempts to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount payable under the Plan, or any part thereof, or if a person's bankruptcy or other event would cause amounts payable under the Plan to be subject to the person's debts or liabilities, then the Plan Administrator may direct that such amount be withheld and that the same or any part thereof be paid or applied to or for the benefit of the Participant in such manner and proportion as the Plan Administrator may deem proper. Such payment shall constitute a complete discharge of the liability of the Benefit Program, the Company, the Plan Administrator, the Plan, and their authorized delegates.

A Participant may request and authorize the Plan Administrator or the appropriate Insurance Company or service provider to pay benefits directly to the hospital, physician, dentist, or other person furnishing services or supplies covered under the applicable Benefit Program and any such payment, if made, shall constitute a complete discharge of the liability of the Benefit Program, the Company, the Plan Administrator, the Plan, and their authorized delegates.

In no event may the Participant or any beneficiary of the Participant assign or transfer any right exercisable against the Plan, including but not limited to the right to request documents under ERISA Section 104, or to initiate claims (including but not limited to

claims regarding eligibility, breach of fiduciary duty, or civil penalties). These rights are not assignable in whole or in part to any person, provider, or other entity, nor may these rights be transferred, before or after services are provided. Any such attempted assignment or transfer shall be null and void.

To the extent required by applicable law, the Plan will honor a qualified medical child support order (QMCSO). A QMCSO assigns benefits to a child who has been designated as an alternate recipient.

K. Company's Use of Funds

To the maximum extent permitted by applicable law, the Company shall be entitled to retain any policy dividend or refund, or portion thereof, it receives from any Insurance Company, administrative services organization, HMO, or any other organization or individual, that exceeds the amount necessary to fund the benefits provided by any particular Benefit Program.

L. Plan's Use of Funds

All amounts paid to and held by the Plan, as well as any policy dividends and/or refunds not belonging to the Company, shall be available without limit to fund the benefits provided by any Benefit Program included in the Plan or any Benefit Program added to the Plan. To the maximum extent permitted by applicable law, the Plan Administrator, in its sole and unfettered discretion, may use funds accumulated under this Plan for any Benefit Program (whether funds accumulated from insurance contract reserves, Insurance Company refunds or dividends, participant or Company contributions, or administrative fees) to reduce the level of contributions that the Company otherwise would make to the Plan for any Benefit Program. Such use of funds may occur without there being any effect on participant contributions otherwise applicable.

M. Lost Recipient

To the extent administratively practicable (and subject to vendor practices), if the Plan Administrator is unable to locate (or establish the identity of) a person to whom a benefit under the self-funded portion of the Plan is payable, that benefit will be forfeited immediately. Should such a person subsequently file a valid claim for benefits with the Plan Administrator within 365 days of the date of the forfeiture, the amount treated as a forfeiture (without adjustment for earnings) will be paid.

N. Workers' Compensation

The Plan is not in lieu of, and does not affect any requirement for coverage by, workers' compensation insurance.

O. Withholding of Taxes

Withholding may be applied to amounts paid or payable pursuant to this Plan for Federal, state, local, or other taxes.

P. Collective Bargaining

Collective bargaining agreements provide for participation of certain Former Employees in this Plan. You may examine a copy (or obtain a copy) of any such collective bargaining agreement that applies to you by contacting HR Solutions. You may be

charged for copies of any documents you request. A list of unions whose members participate in this Plan also is available from HR Solutions.

16. Your Rights and Privileges Under ERISA

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

With respect to Benefit Programs governed by ERISA, ERISA provides that all Plan participants have the right to:

A. Receive Information About Your Plan and Plan Benefits

- You can examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites) all documents governing the Plan. This includes insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- By submitting a written request to the Plan Administrator, you can obtain copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and an updated summary plan description. (The administrator can charge you a reasonable fee for the copies.)
- You should receive a summary of the Plan's annual financial report for Benefit Programs that are required to prepare such a report. The Plan Administrator is required by law to provide a copy of any such summary annual report to each Plan participant.

B. Continue Group Health Plan Coverage

You can continue health Benefit Program coverage if there is a loss of that coverage as a result of a qualifying event. You and your Dependents may have to pay for such coverage. For more details, review Section 13 of this SPD, the relevant Benefit Program materials, and the COBRA notice that was mailed to your home. If you need another copy of any of these documents, please contact the COBRA Vendor in Appendix A.

C. 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. These people, called "fiduciaries" of the Plan, have a duty to operate your Plan prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Company, your union, 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.

D. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right (within certain time schedules) to:

- know why this was done,
- obtain copies of documents relating to the decision without charge, and
- appeal any denial.

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 your copy within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

After exhausting your appeal rights, you may file suit in a state or Federal court if you have a claim for benefits which is denied or ignored, in whole or in part. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court after exhausting your appeal rights.

You may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court if:

- Plan fiduciaries misuse the Plan's money; or
- You are discriminated against for asserting your rights.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

E. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator (see, Appendix H). If you have any questions about this statement or about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act, and other laws affecting group health plans, or need assistance in obtaining documents from the Plan Administrator. you should contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA offices are available through the EBSA website. These telephone numbers also are listed in your telephone directory. You also may contact 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 or www.askebsa.dol.gov. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or on the internet at

www.dol.gov/ebsa. For more information about the Health Insurance Marketplace, visit www.HealthCare.gov.

F. Please Keep the Plan Informed of Address Changes

Participants should let the Plan Administrator know about any change in their address and/or of any change in address of Family Members.

G. HIPAA Privacy Practices

To review the Plan's Notice of Privacy Practices, go to hr.sandia.gov and search "HIPAA." Participants who would like a paper copy should contact HR Solutions at (505-284-4700).

Appendix A: Directory of Benefit Programs

NTESS Post-Employment Health and Welfare Benefits Plan
(For Employees who Terminated Employment Before January 1, 2012)

This chart outlines cost sharing, financing, and day-to-day administration for Benefit Programs offered under the Plan. Medicare benefits are governed by the Medicare statute and regulations. See, Appendix I (Medicare) for additional information.

Benefit Program	Cost Sharing	Financing	Insurance Company/ Day to Day Administrator
Medical – Pre-Medicare UHC-Total Health PPO Sandia Group #0708576	Paid by Company and by Participant	Self-funded	UnitedHealthcare 877-835-9855 (customer service) Dedicated Customer Advocate contact can be found at hr.sandia.gov on the Get to Know our Benefit Providers site www.whyuhcsnl.com
Medical – Pre-Medicare BCBSNM-Total Health PPO Sandia Group #113959	Paid by Company and by Participant	Self-funded	Blue Cross Blue Shield of New Mexico 877-498-7652 (customer service) Dedicated Customer Advocate contact can be found at hr.sandia.gov on the Get to Know our Benefit Providers site www.bcbsnm.com/sandia
Medical – Pre-Medicare (Includes Prescription Drug Program) Kaiser-Total Health PPO Sandia Group: #00110004	Paid by Company and by Participant	Self-funded	Kaiser (CA) 877-568-0774 Dedicated SNL member line 800-663-1771 Customer Service Kaiser Sandia Dedicated Site
Medical – Pre-Medicare Health Reimbursement Account linked with UHC & BCBSNM- Total Health PPO	Paid by Company	Self-funded	Inspira Financial (Formerly Payflex) PO Box 8396 Omaha, NE 68108-0396 844-729-3539 inspirafinancial.com
Medical – Pre-Medicare Health Reimbursement Account linked with Kaiser-Total Health PPO	Paid by Company	Self-funded	Kaiser Permanente Insurance Company 877-750-3399 www.kp.org/healthpayment

Benefit Program	Cost Sharing	Financing	Insurance Company/ Day to Day Administrator
Medical – Pre-Medicare UHC - High Deductible Health Plan Sandia Group: # 9798576	Paid by Company and by Participant	Self-funded	UnitedHealthcare 877-835-9855 (customer service) Dedicated Customer Advocate contact can be found at hr.sandia.gov on the Get to Know our Benefit Providers site www.whyuhcsnl.com
Medical – Pre-Medicare BCBSNM - High Deductible Health Plan Sandia Group: # 285916	Paid by Company and by Participant	Self-funded	Blue Cross Blue Shield of New Mexico 877-498-7652 (customer service) Dedicated Customer Advocate contact can be found at hr.sandia.gov on the Get to Know our Benefit Providers site www.bcbsnm.com/sandia
Medical – Pre-Medicare Prescription Drug Express Scripts (ESI) For those enrolled in Pre-Medicare medical plans administered by UHC & BCBSNM	Paid by Company and by Participant	Self-funded	Express Scripts (ESI) 877-817-1440 (customer service) www.express-scripts.com/sandia
COBRA Vendor – Pre-Medicare & Medicare Health Care Continuation Coverage UHC Services (UHC Benefit Services)	Paid by Participant	Self-funded	UHC Services (UHC Benefit Services) PO Box 740221 Atlanta, GA 30374-0221 877-237-8576 www.uhcservices.com
Dental Program – Pre-Medicare & Medicare Delta Dental of New Mexico Sandia Group: # 9550	Paid by Company and by Participant	Self-funded	Delta Dental of New Mexico 800-264-2818 (customer service) www.deltadentalnm.com
Medical – Medicare Humana Group Medicare Advantage HMO Plan Sandia Group: Plan 076 Option 652	Paid by Company and by Participant	Fully Insured	866-396-8810 humana.com
Medical – Medicare Kaiser Senior Advantage Group HMO Sandia Group: #7455	Paid by Company and by Participant	Fully Insured	800-464-4000 healthy.kaiserpermanente.org

Benefit Program	**Cost Sharing**	**Financing**	**Insurance Company/ Day to Day Administrator**
Medical – Medicare UnitedHealthcare Group Medicare Advantage PPO Plan Sandia Group: #24978	Paid by Company and by Participant	Fully Insured	844-496-0314 retiree.uhc.com/sandiaretiree
Medical – Medicare Your Spending Arrangement (YSA) Program Reimbursement Account linked to individual Medicare benefits, which you enroll in through Via Benefits	Paid by Company	Self-funded	Via Benefits 38 East Scenic Pointe Drive Suite 200 Draper, UT 84020 1-888-598-7809 my.viabenefits.com/sandia
Primary Group Term Life Insurance Benefit Program for Long Term Disability Terminees	Paid by Company	Fully Insured	The Prudential Insurance Company of America 751 Broad Street, Newark, NJ, 07102 800-778-3827 www.prudential.com/mybenefits
Retiree Life Insurance Benefit Program	Paid by Company	Fully Insured	The Prudential Insurance Company of America 751 Broad Street, Newark, NJ, 07102 800-778-3827 www.prudential.com/mybenefits

Appendix B: Benefit Program Materials

NTESS Post-Employment Health and Welfare Benefits Plan
(For Employees who Terminated Employment Before January 1, 2012)

The following Benefit Program Materials, together with any updates (including any Summary of Material Modifications (SMM), enrollment materials, and any Summary of Benefits and Coverage hereby are incorporated by reference into the SPD and the Plan. Benefit Program Materials listed below can be found online. These documents are available electronically at sandiaretireebenefits.com or hr.sandia.gov. Should you prefer to receive a paper copy please contact the Post-Employment TPA. Medicare benefits are governed by the Medicare statute and regulations. See, Appendix I (Medicare) for additional information.

Benefit Program	**Benefit Program Materials** **Links referenced below can be found on hr.sandia.gov**
Medical – Pre-Medicare UHC-Total Health PPO Sandia Group #0708576	Website: www.whyuhcsnl.com https://www.sandiaretireebenefits.com/program-summaries.html • UHC Program Summary • Summary of Benefits Coverage (SBC) • Required Notices (also available in the annual Post-Employment Open Enrollment materials.)
Medical - Pre-Medicare BCBSNM-Total Health PPO Sandia Group #113959	Website: https://www.sandiaretireebenefits.com/program-summaries.html • BCBSNM Program Summary • Summary of Benefits Coverage (SBC) • Required Notices (also available in the annual Post-Employment Open Enrollment materials.)

Benefit Program	Benefit Program Materials Links referenced below can be found on **hr.sandia.gov**
Medical – Pre-Medicare (Includes Prescription Drug Program) Kaiser-Total Health PPO Sandia Group: #00110004	Website: Kaiser Sandia Dedicated Site www.sandiaretireebenefits.com/program-summaries • Kaiser Program Summary • Summary of Benefits Coverage (SBC) • Required Notices (also available in the annual Post-Employment Open Enrollment materials.)
Medical – Pre-Medicare Health Reimbursement Account linked with UHC & BCBSNM-Total Health PPO	Or visit https://www.sandiaretireebenefits.com/content/mercer-consumer/retiree-sites/sandia-home/pre-medicare-plans/health-reimbursement-account.html
Medical – Pre-Medicare Health Reimbursement Account linked with Kaiser-Total Health PPO	Please refer to the Kaiser Program Summary https://www.sandiaretireebenefits.com/content/mercer-consumer/retiree-sites/sandia-home/pre-medicare-plans/health-reimbursement-account.html
Medical – Pre-Medicare UHC - High Deductible Health Plan Sandia Group: # 9798576	Website: https://www.sandiaretireebenefits.com/program-summaries.html • UHC HDHP Program Summary • Summary of Benefits Coverage (SBC) •
Medical – Pre-Medicare BCBSNM - High Deductible Health Plan Sandia Group: # 285916	Website: https://www.sandiaretireebenefits.com/program-summaries.html • BCBSNM HDHP Program Summary • Summary of Benefits Coverage (SBC) • Required Notices

Benefit Program	Benefit Program Materials Links referenced below can be found on hr.sandia.gov
Medical – Pre-Medicare Prescription Drug Express Scripts (ESI) For those enrolled in Pre-Medicare medical plans administered by UHC & BCBSNM	https://www.sandiaretireebenefits.com/program-summaries.html
COBRA Vendor – Pre-Medicare & Medicare Health Care Continuation Coverage UHC Services (UHC Benefit Services)	https://www.sandiaretireebenefits.com/program-summaries.html
Dental Program – Pre-Medicare & Medicare Delta Dental of New Mexico Sandia Group: #9550	https://www.sandiaretireebenefits.com/program-summaries.html
Medical – Medicare Humana Group Medicare Advantage HMO Plan Sandia Group: Plan 076 Option 652	866-396-8810 humana.com
Medical – Medicare Kaiser Senior Advantage Group HMO Sandia Group #7455	800-464-4000 healthy.kaiserpermanente.org
Medical – Medicare UnitedHealthcare Group Medicare Advantage PPO Plan Sandia Group: #24978	844-496-0314 retiree.uhc.com/sandiaretiree

Benefit Program	**Benefit Program Materials** **Links referenced below can be found on** **hr.sandia.gov**
Medical – Medicare Your Spending Arrangement (YSA) Program Reimbursement Account linked to individual Medicare benefits, which you enroll in through Via Benefits	Via Benefits 38 East Scenic Pointe Drive Suite 200 Draper, UT 84020 1-888-598-7809 my.viabenefits.com/sandia
Primary Group Term Life Insurance Benefit Program for Long Term Disability Terminees	hr.sandia.gov > Money > Life Insurance Benefits • Sandia-Paid Life and Accident Insurance Coverage • Contacts and Resources hr.sandia.gov > Resources > Benefit Plan Documents • Summary Plan Descriptions (SPD) • Employee Benefits Eligibility Grid • Required Notices
Retiree Life Insurance Benefit Program	hr.sandia.gov > Money > Life Insurance Benefits • Sandia-Paid Life and Accident Insurance Coverage • Contacts and Resources hr.sandia.gov > Resources > Benefit Plan Documents • Summary Plan Descriptions (SPD) • Employee Benefits Eligibility Grid • Required Notices

Appendix C: Claims Administrators

NTESS Post-Employment Health and Welfare Benefits Plan
(For Employees who Terminated Employment Before January 1, 2012)

If you have questions or concerns about a Benefit Program, you are encouraged to communicate with the Post-Employment TPA (see Appendix H). If you are not satisfied with this communication, the Post-Employment TPA will put you in contact with the appropriate Claims Administrator for the Benefit Program about which you are concerned, and that Claims Administrator will provide you with its standard Claims and Appeals Procedure. ***Please direct claims and appeals of denied claims to the Claims Administrator listed below for the relevant Benefit Program.***

Unless otherwise indicated below, the Claims Administrator listed below has full discretionary authority to administer and interpret the Benefit Program(s) in question and to grant or deny claims and appeals under that Benefit Program.

For Eligibility Claims, see the last row of this chart, and Appendix D (Eligibility Claims and Appeals Procedures).

For Medical and Dental Care Benefit Program Claims, see the appropriate Benefit Program listing below, and Appendix E (Medical and Dental Care Benefit Program Claims and Appeals Procedures).

For Life Insurance Claims, see the appropriate Benefit Program listing below, and Appendix F (Life Insurance Benefit Program Claims and Appeals Procedures).

The Claims Administrators reserve the right to obtain and exchange benefit information with other organizations, claims administrators, carriers, and individuals to determine what other coverage you have.

Medicare claims are governed by the Medicare statute and regulations. See, Appendix I (Medicare) for additional information.

Benefit Program	Claims Administrator
Post-Employment TPA (Initial contact for Post-Employment Benefit Program Eligibility, Enrollment and YSA Claims and Appeals)	Via Benefits 38 East Scenic Pointe Drive Suite 200 Draper, UT 84020 1-888-598-7809 my.viabenefits.com/sandia sandiaretireebenefits.com

Benefit Program	Claims Administrator
Medical – Pre-Medicare UHC-Total Health PPO Sandia Group: #0708576	Health Care Account Service Center PO Box 981506 El Paso, TX 79998-1506 Customer Service:800-331-0480 Fax: 915-231-1709 Toll Free Fax: 866-262-6354
Medical – Pre-Medicare BCBSNM-Total Health PPO Sandia Group: #113959	Blue Cross and Blue Shield of New Mexico PO Box 11968 Albuquerque, NM 87192-0968 Customer Service: 877-498-7652 https://www.bcbsnm.com/sandia/forms (Pull forms online)
Medical – Pre-Medicare (Includes Prescription Drug Program) Kaiser-Total Health PPO Sandia Group: #00110004	Medical Claim: Kaiser Permanente Insurance Company (KPIC) Claims Administrator PO Box 30547 Salt Lake City, UT 84130-0547 Pharmacy Claim: OptumRx Manual Claims PO Box 650334 Dallas, TX 75265-0335
Medical – Pre-Medicare Health Reimbursement Account linked with UHC & BCBSNM-Total Health PPO	Inspira Financial (Formerly Payflex) PO Box 8396 Omaha, NE 68108-0396 inspirafinancial.com
Medical – Pre-Medicare Health Reimbursement Account linked with Kaiser-Total Health PPO	Kaiser Permanente Customer Service: 877-750-3399 www.kp.org/healthpayment
Medical – Pre-Medicare UHC- High Deductible Health Plan Sandia Group: # 9798576	Health Care Account Service Center PO Box 981506 El Paso, TX 79998-1506 Customer Service: 800-331-0480 Fax: 915-231-1709 Toll Free Fax: 866-262-6354

Benefit Program	Claims Administrator
Medical – Pre-Medicare BCBSNM - High Deductible Health Plan Sandia Group: # 285916	Blue Cross and Blue Shield of New Mexico PO Box 11968 Albuquerque, NM 87192-0968 Customer Service: 877-498-7652 https://www.bcbsnm.com/sandia/forms (Pull forms online)
Medical – Pre-Medicare Prescription Drug Express Scripts (ESI) For those enrolled in Pre-Medicare medical plans administered by UHC & BCBSNM	Express Scripts ATTN: Commercial Claims PO Box 14711 Lexington, KY 40512-4711 Customer Service: 1-877-817-1440 Fax: 608-741-5475
COBRA Vendor- Pre-Medicare & Medicare Health Care Continuation Coverage UHC Services (UHC Benefit Services)	UHC Services (UHC Benefit Services) PO Box 740221 Atlanta, GA 30374-0221 Customer Service: 877-237-8576 uhcservices.com
Dental Program – Pre-Medicare & Medicare Delta Dental of New Mexico Sandia Group: #9550	Delta Dental of New Mexico 100 Sun Avenue, Suite 400 Albuquerque, NM 87109 Member Services: 800-264-2818 www.deltadentalnm.com
Medicare – Medical Humana Group Medicare Advantage HMO Plan Sandia Group: Plan 076 Option 652	866-396-8810 humana.com
Medicare - Medical Kaiser Senior Advantage Group HMO Sandia Group: #7455	800-464-4000 healthy.kaiserpermanente.org
Medical - Medicare UnitedHealthcare Group Medicare Advantage PPO Plan Sandia Group: #24978	844-496-0314 retiree.uhc.com/sandiaretiree

<table>
<tr><th>Benefit Program</th><th>Claims Administrator</th></tr>
<tr><td>Medical – Medicare

Your Spending Arrangement (YSA) Program

Reimbursement Account linked to individual Medicare benefits, which you enroll in through Via Benefits</td><td>Via Benefits
38 East Scenic Pointe Drive
Suite 200
Draper, UT 84020

Customer Service: 1-888-598-7809
my.viabenefits.com/sandia</td></tr>
<tr><td>Primary Group Term Life Insurance Benefit Program for Long Term Disability Terminees.</td><td>hr.sandia.gov > Money > Life Insurance Benefits
• Sandia-Paid Life and Accident Insurance Coverage
• Contacts and Resources
hr.sandia.gov > Resources > Benefit Plan Documents
• Summary Plan Descriptions (SPD)
• Required Notices</td></tr>
<tr><td>Retiree Life Insurance Benefit Program</td><td>hr.sandia.gov > Money > Life Insurance Benefits
• Sandia-Paid Life and Accident Insurance Coverage
• Contacts and Resources
hr.sandia.gov > Resources > Benefit Plan Documents
• Summary Plan Descriptions (SPD)
• Required Notices</td></tr>
<tr><td>ERISA Claim and Appeal for eligibility to participate in a Benefit Program</td><td>NTESS
Senior Manager of Benefits
PO Box 5800, MS 1502
Albuquerque, NM 87185-1502
Appeal Email Address Only:
snlbenefits@sandia.gov</td></tr>
</table>

Appendix D: Eligibility Claims and Appeal Procedures

NTESS Post-Employment Health and Welfare Benefits Plan
(For Employees who Terminated Employment Before January 1, 2012)

The Claims and Appeals Procedures in this Appendix are for use in determining **eligibility to participate in a Benefit Program.** If your eligibility claim is part of a claim for a specific benefit under a Benefit Program (e.g., you are asking for coverage for a specific medication that you've already purchased), please refer to Appendix C for a list of Claims Administrators and their contact information, Appendix E for Medical and Dental Care Benefit Program Claims and Appeals Procedures, and/or Appendix F for Life Insurance Benefit Program Claims and Appeals Procedures.

If you are seeking participation in a Benefit Program, you are encouraged to begin by communicating with the Post-Employment TPA (see, Appendix H for contact information).

If the Post-Employment TPA determines you are not eligible to participate in a Benefit Program, and you are not satisfied with this determination, you (or an authorized representative acting on your behalf) may make a formal claim for participation in that Benefit Program by following the procedures outlined below. In this Appendix, you (or an authorized representative acting on your behalf) collectively are referred to as the "Claimant."

Please note that a Claimant may not make a formal claim for participation in a Benefit Program more than one hundred eighty (180) calendar days after the date the Claimant has knowledge of all material facts that are the subject of the claim.

The Claimant must file a formal written claim for participation in a Benefit Program with the Senior Manager of Benefits P.O. Box 5800, MS 1502, Albuquerque, NM 87185-1502. Within 90 calendar days following receipt of such a properly submitted written claim, the Senior Manager of Benefits will give the Claimant either a written notice of the Senior Manager's decision or, if special circumstances require an extension of time for review, a notice of a 90-day extension of the review period.

If a claim is denied in whole or in part, the Senior Manager of Benefits will give the Claimant written notification that will include:

(a) The specific reason for the denial,

(b) Specific references to pertinent Benefit Program provisions on which the denial is based,

(c) A description of any additional material or information that needs to be submitted with an explanation of why the material or information is necessary,

(d) An offer to provide the Claimant, on request, free of charge, reasonable access to and copies of documents, records, and other information relevant to the claim, and

(e) A description of the review procedures and the time limits applicable to the Claimant's request for participation in the Benefit Program and, if applicable, the

Claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

If the Claimant wants to appeal a denied claim for participation in a Benefit Program, the Claimant must submit a written appeal to the Employee Benefits Committee (EBC) Secretary, P.O. Box 5800, MS 1502, Albuquerque, NM 87185-1502. The deadline for submitting any such appeal will be 60 calendar days after the Claimant receives written notification of the denial of the claim, as described above.

Within 60 calendar days following receipt of the appeal, the EBC will give the Claimant either a written notice of its decision or, if special circumstances require an extension of time for review, a notice of a 60-day extension of the review period. The review of the EBC will take into account all comments, documents, records, and other information the Claimant submits, without regard to whether that information was submitted or considered in the initial benefit determination. If the appeal is denied, the notification will:

(a) Explain the specific reasons, and specific Benefit Program provisions on which the decision is based,

(b) Include a statement regarding the Claimant's right (if any) to bring a civil action under ERISA 502(a), and

(c) Offer to provide the Claimant, on request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Claimant's claim.

The EBC has the exclusive, full, and final authority to hear and determine appeals of Benefit Program eligibility claims denied by the Senior Manager of Benefits. The decision of the EBC will be the final and conclusive administrative review proceeding with respect to eligibility to participate in a Benefit Program.[3]

A Claimant is required to pursue all administrative and appeals procedures described above as a precondition to challenging the denial of a claim for participation in a Benefit Program in a lawsuit. In addition, **a Claimant may not submit a dispute to a court with respect to a denied claim for participation in a Benefit Program more than one hundred eighty (180) calendar days after the date the EBC renders its final decision on appeal**.

When determining whether to approve or deny a claim for participation in a Benefit Program, the Senior Manager of Benefits and the EBC have full discretionary authority to administer and interpret the Benefit Program in question, and to determine eligibility for participation under that Benefit Program.

[3] Note: If a Claimant is removed, retroactively from coverage under a health Benefit Program, that recission of coverage may qualify for "External Review." See, Appendix E (Medical and Dental Care Benefit Program Claims and Appeals Procedures) for information about "External Review."

Appendix E: Medical and Dental Care Benefit Program Claims and Appeal Procedures

NTESS Post-Employment Health and Welfare Benefits Plan (For Employees who Terminated Employment Before January 1, 2012)

If you have questions or concerns about your Company-provided medical or dental care benefits, you are encouraged to communicate with the Post-Employment TPA (see, Appendix H). If you are not satisfied with this communication, the Post-Employment TPA will put you in contact with the appropriate Claims Administrator for the medical or dental care Benefit Program about which you are concerned, and that Claims Administrator will provide you with its standard Claims and Appeals Procedure.

Below is an example of a “standard” medical and dental benefit Claims and Appeals Procedure.

You must follow the Claims and Appeals Procedure established by the applicable medical or dental care Benefit Program. If you are required to file an initial claim for benefits, you must do so within the time specified by the Benefit Program, and in accordance with the Benefit Program’s established procedures. **See, Appendix C for a list of Claims Administrators and their contact information. See, Appendix F for Life Insurance Benefit Program Claims and Appeals Procedures, and Appendix D for Eligibility Claims and Appeals Procedures.**

Unless specifically provided to the contrary in the actual Claims and Appeals Procedures, a Claimant may not make a formal claim more than one-hundred eighty **(180) calendar days after the date** the Claimant has knowledge of all material facts that are the subject of the Claim.

A. Definitions

- Claim. A request for medical or dental Benefit Program benefits made to the proper person in accordance with the Benefit Program’s claims filing procedures, including any request for a service that must be pre-approved. A claim includes a challenge to the Plan’s rescission of medical or dental benefit coverage. Claims must be submitted in writing to the appropriate Claims Administrator (see, Appendix C). Medical and Dental Benefit Program claims are divided into four categories: Urgent Care Claims, Pre-Service Claims, Post-Service Claims, and Concurrent Care Decisions. Different rules and timeframes apply to each type of claim, as described below.

- Urgent Care Claim. A claim for medical or dental care or treatment that has to be decided more quickly because the normal timeframes for decision-making could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician or dentist with knowledge of your condition, subject you to severe pain that can’t be adequately managed without the care or treatment addressed in the claim.

- Pre-Service Claim. A claim for a medical or dental benefit – other than an Urgent Care Claim – that must be approved in advance of receiving medical or dental care (for example, requests to pre-certify a hospital stay or for pre-approval under a utilization review program).

- Post-Service Claim. Any other type of medical or dental claim including a claim for reimbursement through a Health Reimbursement Account ("HRA").

- Concurrent Care Decision. A decision in which the Program – after having previously approved an ongoing course of medical or dental treatment provided over a period of time or a specific number of treatments – subsequently reduces or terminates coverage for the treatments (other than by Benefit Program amendment or termination).

- Adverse Decision or Adverse Decision on Appeal. A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit.

- Authorized Representative. You may authorize an individual (your "authorized representative") to act on your behalf in pursuing a claim or an appeal in accordance with procedures established by a medical or dental Benefit Program. For Urgent Care Claims, a health care professional with knowledge of your medical or dental condition may act as your authorized representative. (A health care professional is a physician, dentist, or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with state law.) For information about appointing an authorized representative, contact the Claims Administrator (see, Appendix C).

B. Insufficient Claims

1. Improperly Filed Pre-Service Claim. If a Pre-Service Claim is not filed in accordance with the Benefit Program's claim procedures, you will be notified as soon as possible, but no later than five calendar days after it is received by the Benefit Program. If the claim is an Urgent Care Claim, you will be notified within 24 hours. Notice of an improperly filed Pre-Service Claim may be provided orally – or in writing if you request. The notice will identify the proper procedures to be followed in filing the claim.
In order to receive notice of an improperly filed Pre-Service Claim, you must have communicated your request regarding the claim to the applicable Claims Administrator (see, Appendix C). The request must include:

- the identity of the claimant,
- a specific medical or dental condition or symptom, and
- a request for approval for a specific treatment, service or product.

2. Incomplete Urgent Care Claims. If a properly filed Urgent Care Claim is missing information needed for a coverage decision, you will be notified by the Benefit Program as soon as possible, but no later than 24 hours after the claim has been received by the Claims Administrator.

You will have a reasonable amount of time considering the circumstances (but not less than 48 hours) to provide the specific information. The Claims Administrator will then provide notice of the claim decision as soon as possible, but no later than 48 hours after the earlier of:

- the date the Claims Administrator receives the specified information; or
- the end of the additional time period given for providing the information.

C. Notice of Benefit Determination

1. Notice. A notice of a benefit determination will be provided within a reasonable period of time. In some urgent cases, you may first be provided notice orally, followed by written or electronic notice within 72 hours. If your claim is denied, the notice will identify the claim (e.g., provider of service, date of service), provide specific reasons for the denial, reference Benefit Program provisions on which the denial is based, discuss additional information needed to perfect the claim, describe the Benefit Program's review procedures and associated time limits, confirm that, if the benefit is subject to ERISA, you have the right to bring an action under ERISA Section 502(a) upon completion of applicable claims and appeals procedures, and offer to provide, on request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim (e.g., copies of internal guidelines, and if the decision was based on medical judgment, an explanation of the scientific or clinical reasons for the determination).

2. Standard Timeframes: The standard timeframes for providing a notice of benefit determination are as follows:

- Urgent Care Claims. As soon as possible considering the medical urgency, but not later than 72 hours after the Claims Administrator receives your claim.
- Pre-Service Claims. No later than 15 calendar days after the Claims Administrator receives your claim.
- Post-Service Claims. No later than 30 calendar days after the Claims Administrator receives your claim.
- Adverse Concurrent Care Decisions. If an ongoing course of treatment will be reduced or terminated, you'll be notified sufficiently in advance of the reduction or termination to allow you an opportunity to appeal. If you request an extension of ongoing treatment in an urgent circumstance, you will be notified as soon as possible given the medical urgency, no later than 24 hours after the Claims Administrator receives your claim – provided the claim is submitted to the Claims Administrator at least 24 hours before the expiration of the prescribed time period or number of treatments.

If you request an extension of on-going treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to Post-Service or Pre-Service timeframes, whichever applies.

3. Extended Timeframes. For Pre-Service and Post-Service Claims, the Claims Administrator may extend the standard timeframe for making a decision. If an

extension is necessary, you will be notified before the end of the initial timeframe (15 calendar days for pre-service claims; 30 calendar days for post-service claims) of the reasons for the delay, and when the Claims Administrator expects to make a decision.

If an extension is necessary because certain information was not submitted with the claim, the notice will describe the required information that is missing, and you will be given an additional period of at least 45 calendar days after you receive the notice to furnish the information. The Claims Administrator's extension period will begin when the notification of extension is sent ("Send Date"). When you respond to the request for additional information, the Claims Administrator will have 15 calendar days (plus the number of days between the Send Date and the initial timeframe, as defined above) to notify you of the benefit determination.

D. Appeal of Adverse Decision

If you disagree with the decision on your claim, you may file a written appeal with the applicable Claims Administrator within 180 calendar days after your receipt of the notice of adverse decision. For a list of Claims Administrators, see, Appendix C. If you don't appeal on time, you will lose your right to file suit in a state or Federal court, as you will not have exhausted your internal administrative appeal rights.

You should include the reasons you believe the claim was improperly denied, and all additional facts and documentation you consider relevant in support of your appeal. The decision on your appeal will consider all comments, documentation, and records and other information you submit, even if they were not submitted or considered during the initial claim decision.

A new decision-maker will review your denied claim. The new decision-maker will give the claim a "fresh look" and make an independent decision about the claim.

If your claim was denied based on medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in your claim. The health care professional will not be the same person (or a subordinate of the person) who was consulted on the initial decision. (A medical judgment includes whether a treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate.)

For appeals of adverse benefits decisions involving Urgent Care Claims, the Claims Administrator will accept either oral or written requests for appeals for an expedited review. All necessary information may be transmitted between the Claims Administrator and you (or healthcare professionals acting as your authorized representative) by telephone, fax, or other available expeditious methods.

E. Notice of Decision on Appeal

1. Notice. A notice of decision on appeal will be provided within a reasonable period of time. In some urgent cases, you may first be provided notice orally, followed by written or electronic notice. If your claim is denied on appeal, the notice will identify the claim (e.g., provider of service, date of service), discuss specific reasons for the denial, reference Benefit Program provisions on which the denial is based, confirm that, if the benefit is subject to ERISA, you have the right to bring an action under ERISA Section 502(a) upon completion of applicable claims and appeals

procedures, and offer to provide, on request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim (e.g., identification of experts whose advice was obtained, copies of internal guidelines, and if the decision was based on medical judgment, an explanation of the scientific or clinical reasons for the determination).

Note: Unless specifically provided to the contrary in the actual Claims and Appeals Procedure, a Claimant may not submit a dispute to a court more than one-hundred eighty **(180) calendar days after the date** the Claims Administrator provides notice of its final decision upon appeal.

2. Standard Timeframes. The standard timeframes for providing a notice of decision on appeal are as follows:

- Urgent Care Appeals. As soon as possible considering the medical urgency and no later than 72 hours after the Claims Administrator receives your appeal.
- Pre-Service Appeals. No later than 30 calendar days after the Claims Administrator receives your appeal.
- Post-Service Appeals. No later than 60 calendar days after the Claims Administrator receives your appeal.

F. External Review for Medical Benefit Program Claims

External review is available for a claim that involves (i) a medical judgment, (ii) a rescission of coverage (see, also., Appendix D: "Eligibility Claims and Appeals"), and/or (iii) a surprise bill because you used a non-network provider or an air ambulance. External review is not available for any other type of claim, including claims that are denied because you fail to meet the requirements for coverage under the terms of the Plan, and claims relating to excepted benefits such as the Dental Care Benefit Program.

1. Non-Expedited Requests for External Review

If your claim is denied either at the claim level or any mandatory level of appeal, you may file a written request for an external review with the Claims Administrator, provided the request is filed within 4 months after the date of your receipt of the denial notice. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date falls on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Within 5 business days of the Claims Administrator's receipt of the request for external review, a preliminary review will be conducted to determine whether the request is suitable for external review.

Within one business day after completion of the preliminary review, a written notification will be provided to you as to whether the request is eligible for external review. If the request is complete but not eligible for external review, the notification will include the

reason(s) for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is NOT complete, the notification will describe the information or materials needed to make the request complete. The required information must be provided no later than the last day of the 4-month period after the date of the denial notice (for example, not later than March 1, 2024, for a denial notice dated October 30, 2023) or 48 hours after receipt of the preliminary review notification, whichever is later.

Requests that are eligible for external review will be reviewed by an accredited independent review organization ("IRO"). The IRO will not provide any deference to any prior determination and will not be bound to any decisions or conclusions that were reached by the Claims Administrator. The assigned IRO will provide you with a notice inviting you to submit any additional information that you wish the IRO to consider within 10 business days after the date of the notice.

Additional information that the IRO receives from you will be provided to the Claims Administrator. The Claims Administrator may reconsider its prior denial on the basis of this information. If the denial is reversed and coverage or payment is provided, you will be notified in writing and the external review will be terminated.

The IRO will review any timely received additional information you provide as well as the documents and information the Claims Administrator reviewed in connection with its denial (for example, medical records, attending health care professional's recommendation, the terms of the Plan, appropriate practice guidelines, applicable clinical review criteria developed and used by the Plan, and the opinion of the IRO's clinical reviewer(s)). The IRO will provide you and the Plan with its final external review decision in writing within 45 calendar days after the IRO's receipt of the request for external review. If the IRO's decision reverses the Claim's Administrator's adverse benefit determination or final internal adverse benefit determination, the Plan will provide the coverage or payment for the claim. The Plan may, however, challenge the IRO's decision in court or otherwise.

2. <u>Expedited Requests for External Review</u>

If the adverse benefit determination involves an Urgent Care Claim, you may file a request for an expedited external review of your claim by an IRO, provided you file a request for an internal appeal of the denied claim with the applicable Claims Administrator at the same time.

You also may file a request for an expedited external review by an IRO if your first level appeal has been denied and the appeal involves an Urgent Care Claim or concerns an admission, availability of care, continued stay or health care item or service for which the claimant received emergency services and the claimant has not been discharged from the relevant facility.

The standards and processes described above regarding the preliminary review for eligibility and review by the IRO also apply to expedited requests except that the IRO will provide you and the Plan with its final external review decision no more than 72 hours after the assigned IRO's receipt of the request for external review.

Appendix F: Life Insurance Benefit Program Claims and Appeal Procedures

NTESS Post-Employment Health and Welfare Benefits Plan
(For Employees who Terminated Employment Before January 1, 2012)

This Appendix is designed to address life insurance benefit claims and appeals. If you have questions or concerns about your life insurance benefits, you are encouraged to communicate with the Post-Employment TPA (see, Appendix H for contact information). If you are not satisfied with this communication, the Post-Employment TPA will put you in contact with the appropriate Claims Administrator for the Benefit Program about which you are concerned, and that Claims Administrator will provide you with its standard Claims and Appeals Procedure.

Below is an example of a "standard" Claims and Appeals Procedure for life insurance benefits.

NOTE: You (or your beneficiaries) must follow the actual Claims and Appeals Procedure established by the applicable Benefit Program. If you are required to file an initial claim for benefits, you must do so within the time specified by the Benefit Program and in accordance with the Program's established procedures. **See, Appendix C for a list of Claims Administrators and their contact information. See, Appendix E for Medical and Dental Care Benefit Program Claims and Appeal Procedures, and Appendix D for Eligibility Claims and Appeal Procedures.**

Unless specifically provided to the contrary in the actual Claims and Appeals Procedure, a Claimant may not make a formal claim more than one-hundred eighty **(180) calendar days after the date** the Claimant has knowledge of all material facts that are the subject of the Claim.

A. Definitions

- Claim. A request for Benefit Program benefits made to the proper person in accordance with the Claims Administrator's claims filing procedures. Claims must be submitted in writing to the appropriate Claims Administrator (see, Appendix C).

- Adverse Decision or Adverse Decision on Appeal. A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit.
- Authorized Representative. An individual authorized to act on your behalf in pursuing a claim or appeal, in accordance with procedures established by the Claims Administrator. For information about appointing an authorized representative, contact the Claims Administrator (see, Appendix C).

B. Notice of Adverse Decision

If your claim is denied, in whole or in part, you will be provided with a notice of adverse decision. The notice will provide specific reasons for the denial, reference Benefit Program provisions on which the denial is based, discuss additional information or

materials that needed to be submitted with an explanation of why the material or information is necessary, describe the Benefit Program's review procedures and associated time limits, confirm that, if the benefit is subject to ERISA, you have the right to bring an action under ERISA Section 502(a) upon completion of applicable claims and appeals procedures, and offer to provide, on request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim.

The notice of adverse decision will be provided within 90 calendar days after the date the Claims Administrator receives your claim. If more time is needed by the Claims Administrator to make a decision, you will be notified of the reasons for the delay before the end of the initial 90 calendarday period. The Claims Administrator may extend the decision-making period for up to 90 calendar days if the Program's Claims Administrator determines that special circumstances require an extension.

C. Appeal of Adverse Decision

If you disagree with the decision on your claim, you (or your authorized representative) may file a written appeal, with the applicable Claims Administrator. For a list of Claims Administrators, see, Appendix C. The decision will consider all comments, documentation, and records and other information you submit, even if they were not submitted or considered during the initial claim decision.

The written appeal must be filed within 60 days after the date you receive the notice of adverse decision. You should include the reasons you believe the claim was improperly denied and all additional facts and documentation you consider relevant in support of your appeal. If you don't appeal on time, you will lose your right to file suit in a state or Federal court, as you will not have exhausted your internal administrative appeal rights.

D. Notice of Decision on Appeal

If your appeal is denied, you will receive a notice that provides specific reasons for the denial, references Benefit Program provisions on which the denial is based, confirms that, if the benefit is subject to ERISA, you have the right to bring an action under ERISA Section 502(a) upon completion of applicable claims and appeals procedures, and offers to provide, on request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim. If a voluntary appeals process or alternative dispute resolution is available under the Benefit Program, you also will receive information about these procedures.

Note: Unless specifically provided to the contrary in the actual Claims and Appeals Procedure, a Claimant may not submit a dispute to a court more than one-hundred eighty **(180) days after the date** the Claims Administrator provides notice of its final decision upon appeal.

The Claims Administrator will provide notice of its decision within 60 calendar days after the date the Claims Administrator receives your written appeal. The Claims Administrator may extend the decision-making period for up to 60 calendar days if special circumstances require extra time. You will be notified of the extension prior to the end of the first 60 calendar day period. The notice of extension will indicate the

special circumstances requiring an extension and the date by which the Claims Administrator expects to render the determination on review.

Appendix G: Glossary

NTESS Post-Employment Health and Welfare Benefits Plan
(For Employees who Terminated Employment Before January 1, 2012)

Below are standard definitions used in this Summary Plan Description ("SPD").

Annual Base Pay: For purposes of Life Insurance Benefit Programs offered under this Plan, Annual Base Pay means annual pay plus any lump sum awards (such as Individual Performance Awards, Advancement Awards, and Distinguished Appointment Awards) received by the Former Employee during the 12-month period preceding the Former Employee's Termination of Employment.

Benefit Package: A Retiree Benefit Package, an LTD Terminee Benefit Package, or a Surviving Spouse Benefit Package offered under the Plan. See, Section 2.

Benefit Package Participant: Refers to an enrolled Primary Covered Member and his/her enrolled Dependents. See, Section 4.

Benefit Program: A medical, dental care, or life insurance benefit offered under the Plan.

Benefit Program Materials: See, Appendix B for a list of Benefit Program Materials, which describe Benefit Programs offered under the Plan.

Child/Children: Generally, means the following individuals who are dependents *under the age of 26*:

- A biological child
- A stepchild
- A legally adopted child or a child placed with an individual for adoption
- A child for whom an individual is the court appointed permanent legal guardian
- With respect to medical benefits, a child for whom an individual is required to provide medical benefits pursuant to a Qualified Medical Child Support Order

In addition, the term "Child" includes a Disabled Dependent Child (see definition in this Glossary) whose coverage otherwise would be lost due to age.

Class II Dependent: A Class II Dependent is a member of a closed group of Children over the age of 26 who are participating in a Pre-Medicare Benefit Program offered under a Retiree Benefit Package. No new Class II Dependents can be enrolled. A Class II Dependent must satisfy all of the following conditions to continue coverage:

- Unmarried
- Financially dependent on the Retiree
- Total income, from all sources, of less than $15,000 per calendar year other than support provided by the Retiree

- Lived in the Retiree's home, or one provided by the Retiree in the United States, for the most recent six months, and
- Not eligible for Medicare

NOTE: If a Class II Dependent is disenrolled (e.g., there is a lapse of coverage), the Class II Dependent cannot be re-enrolled.

Company: Currently means National Technology & Engineering Solutions of Sandia, LLC (sometimes referred to in this SPD as "NTESS"). The Company acts through its authorized delegate(s). Prior to May 1, 2017, Company means Sandia Corporation.

Company-Sponsored Medical Benefit Program: A generic term, which is used in this Summary Plan Description to reference Medical Benefit Programs described in Section 6 as well as Medical Benefit Programs offered to participants in the NTESS Health and Welfare Benefits Plan for Active Employees.

Dependent: Generally, refers to a Former Employee's Child and/or Spouse. Divorce or legal separation from the Former Employee will cause a Spouse to lose Benefit Program coverage as a Dependent.

Disabled Dependent Child: Generally means an over-age Dependent Child who is (i) unmarried, (ii) permanently and totally disabled as determined by the applicable medical claims administrator (see, Appendix C), (iii) unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least one year according to the claims administrator, (iv) who lives with a Primary Covered Member, in an institution, or in a home provided by the Primary Covered Member, and (iv) who is financially dependent on a Primary Covered Member. To be eligible for Plan coverage under an applicable Benefit Program, a Disabled Dependent Child must be covered under the applicable Benefit Program and disabled at the time coverage would end due to age. The determination of who is a "Disabled Dependent Child" is made by the applicable claim's administrator, in its sole discretion. Further, the claims administrator will determine the adequacy of any required documentation.

Dual Sandians: Refers to (i) a marriage where each Spouse is either a current or a Former Employee of the Company, or (ii) a parent/child relationship where the parent and the child each are either current or Former Employees of the Company. Dual Sandians may have special rules related to benefit enrollment and benefit coverage.

Employee: Means a common-law Employee of the Company who is eligible to work for the Company as validated through the E- verify system. Employee does not include (and has not at any time included) any individual during any period he or she is not classified as a common-law Employee by the Company, without regard to whether such an individual subsequently is determined to have been a common-law Employee of the Company during this period. The term Employee also can include an individual on a Personal Leave, or a Qualifying Military Leave.

ERISA: ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Family Members: Means the Primary Covered Member and his/her Dependents.

Former Employee: Means an Employee of the Plan Sponsor who has incurred a Termination of Employment. A Former Employee includes, but is not limited to, a Retiree and an LTD Terminee.

HR Solutions: Sometimes referred to as *Sandia HR Solutions*, is the department available to answer questions about Benefit Programs offered under the Plan. See, Section 1 of this Summary Plan Description for additional information.

HRA: Refers to a Health Reimbursement Account. See, Section 6 for additional information.

LTD Medical: Refers to Benefit Programs offering Pre-Medicare and Medicare benefits to individuals covered by the Plan's LTD Benefit Package.

LTD Terminee/Long Term Disability Terminee: For purposes of Medical and Dental Care Benefit Programs, an LTD Terminee/Long Term Disability Terminee is an individual who has (i) Terminated Employment, and (ii) begun to receive long term disability benefit payments from a Company-Sponsored plan (see, Section 2 of this SPD for additional information).

Medicare Start Date: Medicare Start Date is defined in Section 4. The Medicare Start Date is the earliest date an individual can begin participating in a Medicare Benefit Program offered under the Plan.

Net Credited Service: For Primary Group Term Life Insurance purposes, Net Credited Service refers to a Former Employee's Years of Service, including prior employment that has been bridged to form continuous Years of Service with the Company.

Parent Organization: Means any company that owns 80% of the stock of NTESS. As of the date of this Appendix, the Parent Organization is Honeywell International.

Participant: Refers to an enrolled Primary Covered Member and his/her enrolled Dependents.

Plan: Means the *NTESS Post-Employment Health and Welfare Benefits Plan, as that Plan* may be amended from time to time by the Company. This SPD describes Benefit Packages and Benefit Programs currently available under the Plan with respect to certain Employees who Terminated Employment before January 1, 2012, and their Dependents.

Plan Administrator: See, Appendix H: Plan Administration Information for more information about the Plan Administrator within the meaning of ERISA. The Plan Administrator, within the meaning of ERISA, is a Plan fiduciary. The ERISA Plan Administrator acts through its authorized delegate(s).

Plan Sponsor: See definition of Company.

Plan Year: Means the calendar year (January 1 through December 31).

Post-Employment Open Enrollment: Prior to the beginning of each calendar year, the Company offers a limited period of time during which a Primary Covered Member can make Benefit Program elections. The election generally is irrevocable as of

December 31 of the election year and becomes effective the next day (January 1 of the year after the election is made).

Post-Employment TPA: Refers to the Company's Post-Employment Third-Party Benefit Administrator, currently, Via Benefits. The Post-Employment TPA provides day-to-day administrative services for the Plan, and offers Medicare Plans, which can be selected by Medicare-eligible Participants. See, Appendix H for contact information.

Primary Covered Member: The Primary Covered Member with respect to a Retiree Benefit Package or an LTD Terminee Benefit Package is the Former Employee. The Primary Covered Member with respect to a Surviving Spouse Benefit Package is the Surviving Spouse. See, Section 2 for additional information.

Qualifying Event: Under COBRA, an event that would result in the loss of coverage to a qualified beneficiary, if it were not for the requirements under COBRA.

Qualified Medical Child Support Order (QMCSO): See, definition in Section 5.

Regular Employee: Refers to a Company Employee who is on the Company's payroll.

Retire and Retiree: For purposes of this SPD, refers to a Former Employee who, upon Termination of Employment with the Plan Sponsor, is eligible for a Service Pension under the NTESS Retirement Income Plan ("RIP"). This generally means that the Former Employee has met the minimum age and corresponding minimum Years of Service requirement in the table below:

Age	Service
Any Age	30 years
50	25 years
55	20 years
60	15 years
65	10 years

For purposes of eligibility for coverage under a Retiree Benefit Package, the term "Retiree" has a special definition. See, Section 2.A.1 of this Summary Plan Description for this special definition.

Retiree Medical: Refers to Benefit Programs offering Pre-Medicare and Medicare benefits to individuals covered by the Plan's Retiree Benefit Package.

Service Pension Eligible Recipient: See, Section 2.A.1 of this SPD for this special definition.

Service Pension Rehire: See, Section 5 for a definition of Service Pension Rehire.

Spouse: Means the person to whom an individual is legally married within the meaning of federal law. Spouse does not include a domestic partner.

Surviving Child: For purposes of Medical and Dental Care Benefit Programs, a Surviving Child is a Child of a Former Employee who was covered by a Company-

Sponsored Medical Benefit Program on the date of the Former Employee's death and is, as a consequence eligible for coverage under the Plan's Surviving Spouse Benefit Package. (See, Section 2 of this SPD.)

Surviving Spouse: For purposes of Medical and Dental Benefit Programs, a Surviving Spouse is an individual who is eligible for coverage under the Plan's Surviving Spouse Benefit Package. (See, Section 2.)

Surviving Spouse Medical: Refers to Benefit Programs offering Pre-Medicare and Medicare benefits to individuals covered by the Plan's Surviving Spouse Benefit Package.

Terminate Employment (or derivative terms such as Termination of Employment): Means, for purposes of this SPD, the last date on which a Former Employee no longer is carried on the rolls of the Company as the result of a voluntary termination, retirement, discharge, job separation, layoff, or termination/retirement on account of disability. Employees on Company-approved leaves of absence or on disability status are not considered to have Terminated Employment.

Termination Date: Means the date entered into the Company's payroll system as of which the Employee has a Termination of Employment.

Total Disability: Means disabled as determined by the Company's Long Term Disability carrier.

Years of Service: Means the number of Years of Service documented for an Employee or a Former Employee in the Company's payroll system.

YSA Credit: A YSA Credit is available only to Participants in the YSA Benefit Program (see, Section 6). Currently, the "full" YSA Credit increases annually by 50% of the healthcare component of the Consumer Price Index unless the Consumer Price Index results in a decrease. If the Consumer Price Index results in a decrease, the YSA Credit will remain unchanged for that calendar year. The Company applies the "full" YSA Credit (or a percentage of the "full" YSA Credit) to reduce the cost of Medicare coverage purchased pursuant to the YSA Benefit Program, and/or to reduce other costs including Company-Sponsored Dental Benefit Program costs. See, the most current Post-Employment Open Enrollment materials for actual YSA Credit amounts. The amount of YSA Credits (if any) is determined by the Company in its sole discretion.

Appendix H: Plan Administration Information

NTESS Post-Employment Health and Welfare Benefits Plan
(For Employees who Terminated Employment Before January 1, 2012)

Official Plan Name	NTESS POST-EMPLOYMENT HEALTH AND WELFARE BENEFITS PLAN	
Employer/Plan Sponsor	**National Technology and Engineering Solutions of Sandia, LLC (NTESS)**	Contact Information: NTESS PO Box 5800-1502 Albuquerque, NM 87185 Attention: NTESS POST-EMPLOYMENT HEALTH AND WELFARE BENEFITS PLAN Appeal Email Address Only: SNLBenefits@sandia.gov Telephone: 505-284-4700 (HR Solutions)
Employer I.D. Number (EIN)	85-0097942	
Plan Number	**545**	
Type of Plan	The Benefit Programs provided by the Plan are health and welfare benefits, which may include medical, dental, life, and health reimbursement arrangements (also referred to as health reimbursement account or HRA). The YSA is a health reimbursement arrangement. See, Appendix A for additional information.	
Type of Administration/ Insurance Issuers	The Benefit Programs are provided under both self-funded and insured arrangements. See, Appendix A for additional information.	
Plan Funding Medium and Contribution Sources	See, Appendix A.	

Plan Administrator (within the meaning of ERISA)	**National Technology and Engineering Solutions of Sandia, LLC (NTESS)**	Contact Information: NTESS PO Box 5800-1502 Albuquerque, NM 87185 Attention: NTESS Health Plans Appeal Email Address Only: SNLBenefits@Sandia.gov Telephone: 505-284-4700 (HR Solutions)
Post-Employment TPA	**Via Benefits**	38 East Scenic Pointe Drive Suite 200 Draper, UT 84020 1-888-598-7809
Claims Administrator	See, Appendix C.	
Agent for Service of Legal Process	**National Technology and Engineering Solutions of Sandia, LLC (NTESS)** Service of legal process also may be made on the Plan Administrator.	Address: Delaware (Main): Corporation Service Company 251 Little Falls Drive Wilmington, DE 19808 (800) 927-9800 New Mexico: Corporation Service Company MC – CSC1 110 E Broadway St. Hobbs, NM 88240-3465
Plan Year	January 1 – December 31	
Enrollment and Day-to-Day Questions	Post-Employment TPA (see contact information above) For General information: sandiaretireebenefits.com or call 1-888-598-7809	

Appendix I: Medicare

NTESS Post-Employment Health and Welfare Benefits Plan
(For Employees who Terminated Employment Before January 1, 2012)

This Appendix offers basic information about Medicare. Medicare benefits are governed by the Medicare statute and regulations. Official sources of Medicare information include the Social Security Administration (800-772-1213), the Medicare website (www.medicare.gov, and an official government Medicare handbook, entitled "Medicare and You," which can be found at https://www.medicare.gov/publications/10050-LE-medicare-and-you.pdf.)

A Table at the end of this Appendix summarizes selected characteristics of Medicare Supplement Plans (also known as Medigap Plans), Medicare Part D (Prescription Drug Plans) and Medicare Advantage Plans (sometime referred to as Medicare Part C plans) offered by the Company pursuant to the YSA Benefit Program (see, Section 6).

What is Medicare

Medicare, which is administered by the Social Security Administration, is the U.S. federal government health insurance program for:

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare benefits are provided regardless of income level.

Medicare Part A (Hospital Insurance Plan) covers:

- Hospital benefits
- Hospice care
- Home health services
- Skilled nursing facilities (not including nursing homes)

Individuals, age 65 and over who have more than 10 years of Medicare-covered employment, whether or not they have Terminated Employment (and Spouses of those individuals who are age 65 or over) receive Part A coverage at no cost. Individuals who are not eligible for free Medicare Part A coverage generally can enroll by paying the full premium to Medicare.

Medicare Part B (Medical Insurance Plan) covers:

a portion of the following types of charges after an annual Medicare deductible is met:

- Physician services
- Medical services

- Outpatient diagnostic or treatment services

Individuals eligible for Medicare Part A can purchase Medicare Part B by paying a monthly Medicare premium. The payment normally is deducted from the Social Security benefit. Part B premiums are subject to adjustment based on an individual's income.

Medicare Part D (Prescription Drug Insurance Plan) covers:

- A portion of an individual's drug costs.

The Part D premium is not deducted automatically from the Social Security benefit, but deduction often can be arranged by contacting the private Part D Plan provider. Part D premiums are subject to adjustment based on an individual's income.

Enrolling in Medicare

Part A Enrollment

In general, individuals automatically will be enrolled in Medicare Part A if they are receiving benefits from Social Security. Enrollment begins the first day of the month the individual turns age 65, or if the individual is under age 65 and disabled after the individual has received disability benefits from Social Security for 24 months.

If an individual has not automatically been enrolled in Medicare Part A and the individual is eligible for Medicare on account of age or disability (see, e.g., preceding paragraph) the individual should enroll by contacting Social Security Administration at 800-772-1213 or visit www.medicare.gov for more information.

Most people don't have to pay for Medicare Part A if they or their Spouse worked 10 or more years in Medicare-covered employment.

Part B Enrollment

If you are close to age 65 and you aren't enrolled in Medicare Part B, you will need to contact the Social Security Administration at 800-772-1213. Enrollment opportunities generally are available for limited periods of time before and after you attain age 65, before and after you cease to be covered by an employer-sponsored group health plan, and each year during an annual enrollment period. Individuals who do not sign up for Medicare Part B when first eligible may be subject to a Medicare penalty.

Part D Enrollment

Part D refers to optional prescription drug coverage, which is available to all individuals who are eligible for Medicare and is sold by private companies. Individuals who do not sign up for Medicare Part D when first eligible may be subject to a Medicare penalty.

For detailed information about signing up for Medicare Parts A, B, and D, please contact the Social Security Administration, at 800-772-1213, or your local Social Security office.

Medicare Supplement Plans (Medigap)

Medicare Supplement Plans (often referred to as Medigap plans) help fill "gaps" in Original Medicare. You must be enrolled in Medicare Part A and Medicare Part B to

benefit from a Medicare Supplement Plan. A Medicare Supplement Plan pays for much, but not all, of the cost for covered health care services and supplies. Medicare Supplement Plans are sold by private medical insurance companies. A Medicare Supplement Plan (Medigap) policy can help pay some of the remaining health care costs, like:

- Copayments
- Coinsurance
- Deductibles

Some Medicare Supplement Plan (Medigap) policies also cover services that Original Medicare doesn't cover, like medical care when an individual travels outside the United States.

Not all individual Medicare Supplement Plans are available in all areas. You cannot enroll in a Medicare Supplement Plan and a Medicare Advantage Plan.

Medicare Advantage Plans

Medicare Advantage Plans cover all services provided under Medicare Part A and Medicare Part B. You must be enrolled in Medicare Part A and Medicare Part B to benefit from a Medicare Advantage Plan. Certain Medicare Advantage Plans called "Medicare Advantage Prescription Drug Plan (MAPD)" also cover prescription drug services, and some Medicare Advantage Plans cover additional services such as vision benefits.

Medicare Advantage Plans are offered by private medical insurance companies. In most cases, you'll need to use health care providers who participate in the plan's network.

Medicare Advantage Plans have a yearly limit on your out-of-pocket costs for all Medicare Part A and Medicare Part B services. Once you reach this limit, you'll pay nothing for services Medicare Part A and Medicare Part B cover for the remainder of the calendar year.

Medicare Advantage Plans may be limited to certain service areas. You cannot enroll in a Medicare Advantage Plan and a Medicare Supplement Plan.

Summary

The Table below summarizes selected characteristics of Medicare Supplement (Medigap) Plans, Medicare Part D (Prescription Drug Plans), and Medicare Advantage Plans offered by the Company pursuant to the YSA Benefit Program (see, Section 6).

	Medigap/Medicare Supplement Plans	Part D Plans	Medicare Advantage Plans
Description	Supplemental insurance plans sold by private medical insurance companies to fill "gaps" in Original Medicare. These plans, which have alphabetical names (e.g., Plan G, Plan H), offer standardized menus of benefits* Generally, there is no prescription drug coverage.	Medicare Part D plans are offered through private medical insurance companies. Medicare Part D covers generic and brand-name drugs included in the plan's formulary. Prescription drug plans may be purchased separately or as an add-on for Medicare Advantage plans that do not offer a prescription drug benefit (MA) or Medigap plans.	These plans are offered by private medical insurance companies to provide you with all your Medicare Part A and Medicare Part B benefits plus additional benefits. There are two versions: Medicare Advantage Prescription Drug (MAPD) and Medicare Advantage (MA). MAPD plans include prescription drug coverage, MA plans do not.
Deductibles, Copayments, Coinsurance	Most Medigap services are covered with no additional out-of-pocket cost to you. There are no deductibles or coinsurance.	Wide range of copayments, deductibles, and coinsurance.	Most plans require a copayment or coinsurance at the time of service.
Does it include hospital coverage?	Yes	Not applicable	Yes

	Medigap/Medicare Supplement Plans	Part D Plans	Medicare Advantage Plans
Does it cover doctors and specialists?	Doctors and specialists are covered. Any doctor that accepts Original Medicare accepts these plans.	Not applicable.	Doctors and specialists are covered. There are three types of doctor networks: Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and Private Fee for Service.
Does it have prescription drug coverage?	Prescription drugs are not covered. You must enroll separately in a Medicare Part D plan.	Yes	There are two versions: MAPD which includes prescription drugs and MA, which does not.
Does it have dental and vision benefits?	No	No	Dental and vision coverage varies by plan.
Does it cover me when I travel?	These plans are accepted by every Medicare-participating provider in the U.S. with some emergency benefits worldwide. If you travel frequently or live part of the year out-of-state, these plans may be right for you.	These plans provide nationwide coverage through participating pharmacies.	These plans cover urgent and emergency care nationwide, but some may not provide nationwide coverage for non-emergency services. If you live part of the year out-of-state, these plans may not be right for you.
*Massachusetts, Minnesota, and Wisconsin have their own versions of these plans.			

Appendix J: Summary of Permitted Mid-Year Changes

NTESS Post-Employment Health and Welfare Benefits Plan
(For Employees who Terminated Employment Before January 1, 2012)

In general, benefit elections made for a Plan Year (or for the remainder of the Plan Year if the Primary Covered Member enters midyear) may not be changed until the next Post-Employment Open Enrollment period. However, the Primary Covered Member may be permitted to change elections during the Plan Year if the election is consistent with a "Change in Status Event," and is consistent with Benefit Package operation (See, Section 2) and Benefit Program operation (see, Section 6). The Primary Covered Member must notify the Post-Employment TPA within 31 calendar days (60 calendar days for Medicaid/CHIP events and upon the birth or adoption of a child*)* of the Change in Status. See, also, Section 11.

The Primary Covered Member can cancel medical, dental care, and/or life insurance enrollment at any time. Please note, however, that once enrollment is canceled, it may not be possible to re-enroll (see, e.g., Surviving Spouse Benefit Package description in Section 2 of this SPD).

Change in Status Event	Change to Medical or Dental Benefit Program
Gain of Spouse or Dependent Including marriage, birth, adoption and placement for adoption or satisfaction of Dependent eligibility by another event (such as becoming single)	If a Spouse or Dependent is gained, coverage may be increased, the new Spouse or Dependent may be added, and preexisting Spouses and Dependents may be added. If the Spouse or Dependent's plan provides coverage, you may disenroll.
Loss of Spouse or Dependent Including death, legal separation, divorce, annulment, and Dependent ceasing to satisfy Dependent eligibility by other event (such as attaining a certain age)	If the loss of Spouse or Dependent results in loss of other coverage, you may be able to add coverage to replace the coverage that was lost. If coverage was under this Plan, coverage of lost Spouse or Dependent under affected Benefit Program may be revoked.
Change in Employment (causing eligibility under this Plan) Event that changes your, your Spouse's, or your Dependent's employment that results in a gain in eligibility for this Plan. For example, you return to work after a Termination of Employment, or you increase your work hours to 20 or more per week.	An election may be made to enroll in these Benefit Programs.
Change in Employment (causing loss of eligibility under this Plan) Event that changes your or your Spouse's employment that results in a loss of eligibility for this Plan	Coverage elections may be revoked or changed.

Change in Status Event	Change to Medical or Dental Benefit Program
Change in Employment (causing eligibility under another plan) Event that changes your, your Spouse's, or your Dependent's employment that results in gaining eligibility under another employer's plan	Coverage election under affected Benefit Program may be revoked or changed.
Change in Employment (causing loss of eligibility under another plan) Event that changes your Spouse's or your Dependent's employment that results in a loss of eligibility under another employer's plan	Coverage in these Benefit Programs may be increased and/or Spouse and Dependents may enroll in these Benefit Program.
Change in Residence A change in your place of residence or that of your Spouse or Dependent	If a move triggers eligibility, the newly eligible individual may be added as well as other eligible Dependents. If move results in ineligibility, coverage elections may be revoked or changed.
Judgment, Decree or Order (e.g., Qualified Medical Child Support Order) from a court regarding medical insurance or coverage of a child.	If a judgment, decree, or order requires your Dependent child to be covered under the Plan, you may change your election to provide coverage for the child. Conversely, if the order requires another individual to provide coverage, you may change your election to revoke coverage for your child provided the other individual actually provides that coverage.
Entitlement or loss of entitlement to Medicare or Medicaid	Coverage may be canceled or reduced for a person who becomes enrolled in Medicare or Medicaid. Coverage may be prospectively commenced or increased for the person who loses Medicare or Medicaid coverage. (This event generally is not applicable for the Dental Program).
Significant Change in Cost If there is a significant increase or decrease in cost, you may change your election. Whether a change in cost is significant is determined on a group level, not on an individual level. **NOTE:** If there is an insignificant cost change, the Plan may automatically make a corresponding change to your election.	You may either increase or decrease your contribution amounts prospectively and may make a corresponding election to add or drop coverage under a Benefit option providing similar benefits.
Significant Curtailment of Coverage	You may revoke your election and elect another Plan option with similar coverage. In addition, if the Plan adds a new benefit during the Plan Year, you may elect the newly added option. Conversely, if the Plan should drop an existing benefit option, you are allowed to choose another benefit that provides similar coverage.

Change in Status Event	Change to Medical or Dental Benefit Program
Change in Another Plan If coverage changes under another plan because of a change in status or Annual Benefits Enrollment changes (for plans with a different period of coverage).	You may change enrollment, increase benefits, revoke your election, or decrease benefits consistent with other plan's coverage change.
Addition of, or Significant Improvement to Benefit Option	The new or improved option may be added, and other elections may be revoked.

Appendix K: Rehired Retirees

NTESS Post-Employment Health and Welfare Benefits Plan (For Employees who Terminated Employment Before January 1, 2012)

	Service Pension Rehire	**Post-May 2022 Rehire**
1. Definition	"Service Pension Rehire" means a Retiree who, prior to September 2, 2022, incurred a Termination of Employment, was receiving a Service Pension and who, on or after September 2, 2022, and before December 31, 2026, is rehired as a temporary, part-time common law employee of the Company or a Parent Organization.	"Post-May 2022 Rehire" means a Retiree who, *after May 31,* 2022, is rehired by the Company or a Parent Organization, and who does not satisfy the Definition (item 1 of this chart) or the "Temporary Part -Time Employment" (item 2 of this chart) requirements applicable to a Service Pension Rehire. Note: Former Employees who were rehired by the Company or a Parent Organization on or before May 31, 2022, are not eligible to participate in the *NTESS Post-Employment Health and Welfare Benefits Plan* upon rehire or upon final Termination of Employment.
2. Temporary Part-Time Employment	A Service Penson Rehire must provide fewer than 100 Hours of Service per calendar month. Service Pension Rehires who have 100 hours or more of service in a calendar month may be required to repay their monthly pension payment. Please contact HR Solutions (505-284-4700) for additional information.	This 100 Hours of Service requirement does not apply to a Post-May 2022 Rehire. The pension of a Post-May 2022 Rehire may be suspended during re-employment. Please contact HR Solutions (505-284-4700) for additional information.

	Service Pension Rehire	**Post-May 2022 Rehire**
3. Post-Employment Medical and Dental Care Benefit Programs upon Rehire.	A Service Pension Rehire is not eligible to participate in any Post-Employment Medical or Dental Care Benefit Programs offered under the *NTESS Post-Employment Health and Welfare Benefits Plan* during their re-employment.	Same as Service Pension Rehire
4. Active Medical and Dental Care Benefit Program Participation	A Service Pension Rehire must select at least 20 Hours of Service per calendar week schedule in order to participate in a Medical or Dental Care Benefit Program offered to active Employees pursuant to the *NTESS Health and Welfare Benefits Plan for Active Employees.*	Same as Service Pension Rehire
5. Post-Employment Medical and Dental Care Benefit Program Participation upon next Termination of Employment.	A Service Pension Rehire who was eligible to participate in a Post-Employment Medical or Dental Care Benefit Program (See, Section 2) on the date they were rehired will not, solely on account of their rehire, lose eligibility to participate in that Program when they again Terminate Employment from the Company or the Parent Organization that rehired them.	Same as Service Pension Rehire
6. Eligibility Chart (Pre-Medicare, Medicare & Dental Care Benefits)	A Service Pension Rehire will keep their original Hire/Rehire Date within the meaning of the Eligibility Chart in Section 6.	Same as Service Pension Rehire

	Service Pension Rehire	**Post-May 2022 Rehire**
7. Premiums	Upon "final" Termination of Employment, a Service Pension Rehire will not qualify for a more favorable Medical Benefit Program premium/tier level under the *NTESS Post-Employment Health and Welfare Benefits Plan*.	Upon "final" Termination of Employment, a Post-May 2022 Rehire may qualify for a more favorable Medical Benefit Program premium/tier level under the *NTESS Post-Employment Health and Welfare Benefits Plan* based on their additional Years of Service (see, Section 10).
8. Retiree Life Insurance	A Service Pension Rehire who was eligible for coverage under the Retiree Life Insurance Benefit Program (see, Section 8) will retain that coverage while working as a Service Pension Rehire and when they again Terminate Employment from the Company or the Parent Organization that rehired them.	A Post-May 2022 Rehire, who was eligible for coverage under the Retiree Life Insurance Benefit Program (see, Section 8) will lose that coverage at the end of the month of rehire, and that coverage will not be reinstated, regardless of prior service. For information regarding life insurance conversion coverage, **before you rehire,** please contact HR Solutions at 505-284-4700.