THE LINCOLN ELECTRIC COMPANY
WELFARE BENEFITS PLAN

Amended and Restated
Effective as of January 1, 2020

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The Lincoln Electric Company Welfare Benefits Plan

I. PURPOSE

The Lincoln Electric Company (the "Company") sponsors this Plan for the purpose of providing various welfare programs and fringe benefit plans (the "Programs") for the exclusive benefit of Participants. The Plan is a welfare benefit plan, as defined in ERISA. This document is intended to satisfy the requirements of ERISA and qualify as a health plan under Code section 105(e). Benefits received under the Plan are intended to be excluded from gross income under Code sections 104, 105(b), and 106.

II. DEFINITIONS

2.1 "Claims Fiduciary" means (a) with respect to any Insured Program, the person or entity designated by the Insured Program to process and/or review claims for benefits under the Insured Program; and (b) with respect to any Self-Insured Program, the third party administrator, insurance company or other organization or individual to which the Company or the Plan Administrator has delegated the duty to process and/or review claims for benefits under a Self-Insured Program. If no separate Claims Fiduciary has been designated by the Company or the Plan Administrator with respect to a Self-Insured Program, the Plan Administrator will be the Claims Fiduciary for such Self-Insured Program.

2.2 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

2.3 "Code" means the Internal Revenue Code of 1986, as amended.

2.4 "Company" means The Lincoln Electric Company or any successor thereto.

2.5 "**Controlled Group**" means the Company and all other entities the employees of which are treated, pursuant to Code section 414(b) and (c), as if they were employed by a single employer.

2.6 "Dependent" means an individual deriving his or her eligibility solely through an Eligible Employee, and who satisfies the eligibility rules as provided in any Program.

2.7 "**Eligible Employee"** means an Employee who has satisfied the eligibility provisions of at least one of the Programs, the provisions of which are specifically incorporated herein by reference.

2.8 "**Employee**" means a common law employee of a Participating Employer. The term "Employee" excludes temporary employees, seasonal employees, and "leased employees" as defined in Code section 414(n), and as classified by the Participating Employer, even if such classification is in error.

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

2.10 "Insured Program" means those benefits provided under the Plan by certain health maintenance organizations ("HMOs") and insurance companies on an insured basis, as specified in Schedule A hereto. The Insured Programs are subject to this document solely for the purpose of determining Employee and Dependent eligibility. All other terms and conditions of the benefits provided under an Insured Program are determined by the HMO or the insurance company in accordance with its rules and without other application of this Plan, including (a) all applicable definitions; (b) the eligibility, participation, and coverage requirements; (c) descriptions of all services; (d) the benefit amounts payable; (e) claims procedures and qualified medical child support orders; (f) any procedural requirements; and (g) required Participant contributions. In addition, all Insured Programs benefits are administered by the applicable HMO or insurance company. In the event there is any inconsistency between the terms of this Plan and the terms of the HMO or insurance contracts governing the Insured Programs, the terms of the HMO or insurance contracts shall control.

2.11 "Participant" means any Eligible Employee who participates in the Plan in accordance with Article III of this Plan.

2.12 "Participating Employer" means the Company and each Controlled Group member, employees of which the Company has designated as eligible to participate in this Plan. The Participating Employers are listed in Schedule B.

2.13 "Plan" means The Lincoln Electric Company Welfare Benefits Plan, as amended from time to time.

2.14 "Plan Administrator" means the Company or any individuals, committees, or entities that may be appointed from time to time by the Company to administer the Plan pursuant to Article IV.

2.15 "Plan Year" means the twelve-month period beginning on January 1 and ending on December 31 thereafter.

2.16 "Program" means each Insured Program and Self-Insured Program offered to eligible Participants hereunder, as specified in Schedule A hereto. All Programs offered hereunder shall collectively constitute one plan for ERISA and Code reporting and disclosure requirements. Notwithstanding the foregoing, the Plan Administrator may designate one or more Programs as a separate plan for purposes of ERISA and the Code so long as all Programs are designated as part of a separate plan for such purposes. The Programs, which are governed by the terms and conditions herein contained, are set forth in Schedule A and in documents incorporated by reference.

2.17 "Self-Insured Program" means those benefits that are provided under the Plan on a self-insured basis out of the general assets of the Company, as specified in Schedule A hereto.

III. TERMS OF THE PLAN

3.1 Employee Eligibility.

An Employee's eligibility to receive benefits under this Plan shall be dictated by and limited to his eligibility to receive benefits under each Program, as described in the governing document(s) for each Program. An Employee may be an Eligible Employee for purposes of some, but not other, Programs. The eligibility rules for each Program are set forth in the Programs listed in Schedule A.

3.2 Participation.

A "Participant" with respect to this Plan shall be any Eligible Employee who elects to participate in a Program or who automatically participates in a Program in accordance with the terms and conditions established for that Program, and has not for any reason become ineligible to participate further in that Program.

To the extent provided in the Company's severance pay plan or employment or termination agreement with a Participant providing for severance pay and/or a general release of claims against the Company ("Severance Pay Arrangement"), a Participant who qualifies for participation in such Severance Pay Arrangement may be covered hereunder beyond the date such Participant would otherwise have terminated participation in accordance with the provisions of the applicable Summary Plan Description. The Severance Pay Arrangement or any notice given thereunder must be in writing and must set forth any special or additional terms and conditions of participation in any Program under the Plan and, only to that extent, shall be deemed to be incorporated herein.

3.3 Acquisitions and Divestitures.

A written agreement between the Company and a party that is not affiliated with the Company regarding the purchase or sale of a business unit, division, or subsidiary ("Business") may provide for the termination or commencement of the participation of Employees in this Plan or any Program. Absent specific provision in such agreement to the contrary:

(a) each Employee of a Business that is sold will cease being an Eligible Employee upon such sale; and

(b) no employee of a Business that is acquired is eligible for this Plan or any Program, except as the Plan Administrator may specify.

The Plan Administrator may designate any Program applicable to any employees of an acquired Business who are eligible hereunder.

3.4 Insuring and Funding Benefits.

Each Program shall be a Self-Insured Program, an Insured Program, or otherwise funded through a fund or trust, or a combination thereof, and there shall be no funding of the Plan separate from the funding of the Programs.

Self-Insured Program benefits are not funded and are intended to be provided from the general assets of the Company. Nothing herein shall be construed to require the Company to maintain any fund or segregate any amount for the benefit of any Participant and no Participant or other person shall have any claim against or right to, or security or other interest in, any fund, account or asset of the Company from which any Self-Insured Program benefit payment under the Plan may be made. A Participant entitled to Self-Insured Program benefits hereunder shall be a general unsecured creditor of the Company.

Notwithstanding the foregoing, the Company may elect to purchase insurance policies or invest in insurance arrangements to provide Self-Insured Program benefits. Insured Program benefits are paid solely by the applicable HMO or insurance company in accordance with the provisions of the HMO or insurance company agreement(s) and the Company shall not have any further responsibility to pay such Insured Program benefits.

To provide the benefits under the Programs, contributions are made by the Company and by the Participants (including Dependents, where applicable), as determined by the Company.

3.5 Contributions.

The Company may pay all, a portion of, or none of, the cost of Plan benefits for Participants. The Company will not be obligated to contribute to the Plan after Plan termination except to pay expenses incurred but unpaid on the later of the date the Plan termination is adopted or effective.

For each Plan Year, the Company shall establish the applicable level of Participant contribution, if any, for each type of benefit, level of coverage, eligibility group, or status under the Programs. Contribution rates may be updated by the Company from time to time and, for purposes of Article V, incorporated herein by reference without further amendment of the Plan.

For each Plan Year, the Company shall establish the applicable level of Participant and Dependent contributions for each type and level of coverage provided as COBRA coverage under a Program. The Plan Administrator shall set deadlines and other procedures to provide for timely payment of contributions by Participants and to provide for the termination of coverage for failure to make timely payment of contributions. Failure to comply with such deadlines and procedures shall result in termination of participation in the Program to which such failure relates, unless waived by the Plan Administrator in its discretion.

Except as otherwise expressly provided in accordance with the terms of a Program, Participant contributions shall be made on an after-tax basis.

The Company reserves the right to increase, decrease, or otherwise change any contribution requirement during any Coverage Period or Plan Year notwithstanding any determination made in accordance with the foregoing paragraphs.

Participant contributions will be treated as fixed premium obligations, and Participants will not be entitled to any reduction or refund of their contributions (including without limitation applicable deductibles or co-payments) in the event that the claims experience of the Plan is more favorable than projected or the Plan receives any discount, refund, rebate, settlement or damages

pursuant to an agreement with or settlement or judgment with or from any medical provider, Claims Fiduciary or other organization.

3.6 Benefits and Termination of Rights to Benefits.

The benefits available under this Plan shall consist of an aggregation of the benefits available under each Program listed in Schedule A, including all limitations and exclusions with respect to each Program's benefits. A Participant's right to benefits under this Plan shall consist of and be limited to his or her right to benefits under each Program in which he or she is a Participant or Eligible Employee. Any termination or cessation of a Participant's rights or coverage under a Program shall be considered a termination or cessation of those same rights under this Plan. This Plan provides for no rights other than those rights provided for under each Program as applicable to its Eligible Employees and their Dependents. An Employee has no rights to any benefits from any Program for which the Employee is not an Eligible Employee.

3.7 Payment of Benefits.

The benefits under this Plan shall be payable according to the payment provisions of each Program. The payment provisions of each Program are set forth in the Programs listed in Schedule A.

3.8 Conversion Policy.

(a) Self-Insured Programs. There are no conversion options available under the Self-Insured Programs.

(b) Insured Programs. Upon termination of coverage under an Insured Program, a Participant will be able to convert to a personal policy in accordance with the terms of the underlying insurance policy; provided, however, that to the extent permitted under applicable law, the Participant shall be required to pay all expenses (or reimburse the Company for all expenses) necessary for the conversion policy to be issued.

IV. ADMINISTRATION

4.1 Plan Administrator.

The Plan Administrator shall administer this Plan and the Programs and shall be the "named fiduciary" for this Plan and the Programs. Nothing herein shall restrict the Company's right to remove a Plan Administrator at any time.

The Plan Administrator shall be responsible for the day-to-day administration of this Plan and the Programs. The Company's sole responsibility with respect to the administration of this Plan and the Programs is to appoint or remove the Plan Administrator.

4.2 Duties and Powers of the Plan Administrator.

The Plan Administrator shall have the following duties, responsibilities, and authority with respect to the administration of this Plan and the Programs:

(a) complete discretionary authority to construe and interpret this Plan and the Programs including, without limitation, determining any individual's eligibility to participate in and receive benefits under one or more Programs, correcting any defect, supplying and omitting and reconciling any inconsistency;

(b) to prescribe procedures to be followed by Eligible Employees and Participants in making elections, filing claims, and any other administrative procedure necessary to properly administer any or all of the Programs. Notwithstanding any other provision of the Plan or any Program, the Plan Administrator and any Claims Fiduciary may prospectively revise their rules and procedures whenever they deem it appropriate, even if this causes inconsistency with prior decisions or results;

(c) to prepare and distribute information explaining this Plan and the Programs to Eligible Employees and Participants;

(d) to receive from the Company, Eligible Employees, and Participants such information as may be necessary or desirable for the proper administration of this Plan and the Programs;

(e) to employ such persons, including, but not limited to, actuaries, accountants, claims administrators, and counsel, as it deems appropriate, to perform such duties as may from time to time be required either by administrative convenience or necessity or under ERISA or under the Code and to render advice upon request with regard to any matters arising under this Plan or the Programs;

(f) to prepare and file any reports or returns with respect to this Plan and the Programs required under applicable law;

(g) to take all other steps deemed necessary or appropriate to properly administer this Plan and the Programs in accordance with their terms and the requirements of applicable law; and

(h) to act in accordance with all applicable laws governing applicable fiduciary standards.

4.3 Qualified Medical Child Support Orders.

The Plan Administrator shall establish reasonable procedures to determine whether medical child support orders (as defined in ERISA section 609(a)(2)(B)) are qualified medical child support orders (as defined in ERISA section 609(a)(2)(A)) and to administer the provision of benefits under such qualified orders.

4.4 Rules and Decisions.

The Plan Administrator shall decide any matter, and may adopt any rule or procedure, regarding eligibility, benefits, claims, or any other issue arising under this Plan that it deems necessary, desirable, or appropriate in the administration of this Plan and the Programs, including factual determinations. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Eligible Employees and Participants in similar circumstances and shall be conclusive and binding on all persons having an interest in this Plan or any Program. When making any decision or determination, the Plan Administrator or its delegate shall be entitled to rely upon, without further inquiry, such information as may be furnished to it by an Eligible Employee or Participant, the Company, legal counsel, or the administrator of any Program or another plan.

4.5 Indemnity.

To the extent not insured against by any insurance company pursuant to the provisions of any applicable insurance policy, the Company shall indemnify and hold harmless the Plan Administrator from any and all claims, demands, lawsuits, or proceedings in connection with this Plan and the Programs, including the expenses of defense; provided that such indemnification shall not apply to any person for such person's act of willful misconduct or as otherwise prohibited by law.

4.6 Fiduciary Duties and Responsibilities.

Each Plan fiduciary will discharge his or its duties with respect to the Plan solely in the interest of the Participants; for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of administering the Plan; and in accordance with the terms of the Plan. Each fiduciary, in carrying out such duties, will act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in exercising such authority. A fiduciary may serve in more than one fiduciary capacity. Unless liability is otherwise provided under ERISA section 405, a named fiduciary will not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a named fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

4.7 Claims Procedures.

Notwithstanding anything to the contrary herein, the terms of any insurance policy or summary plan description regarding the subject matter described in this Section 4.7 may apply in lieu of or in addition to the provisions of this Section.

(a) Definitions. When capitalized in this Section 4.7, these words and phrases have the following meanings:

(i) "Authorized Representative" means a person authorized in writing by a Covered Person to act on his behalf or a person authorized by a court order to submit claims on behalf of a Covered Person. In the case of an Urgent

Care Claim, a health care professional with knowledge of a Covered Person's condition may always act as the Covered Person's Authorized Representative.

(ii) "Concurrent Care Claim" means a Health Plan Claim that is a claim to continue a course of treatment previously approved by health care benefits program that the Claims Fiduciary proposes to reduce or terminate before the expiration of the time or the number of treatments that was originally approved.

(iii) "Covered Person" means Participants, Dependents, including persons receiving COBRA continuation coverage.

(iv) "Disability Claim" means a claim for a benefit under a Program, the availability of which is conditioned on the claimant's showing of disability.

(v) "Excepted Benefit" means a Program that provides "excepted benefits," as such term is defined under Department of Labor Regulations § 2590.732(c), including limited-scope vision or dental benefits, certain employee assistance programs, certain health flexible spending arrangements, coverage that is only for a specified disease or illness, hospital indemnity or other fixed indemnity insurance, and supplemental excepted benefits (e.g., Medicare supplemental coverage).

(vi) "Health Plan Claim" means a claim for benefits under a Program that provides medical care (including items and services paid for as medical care) to current and/or former employees and their dependents, whether directly or through insurance, reimbursement, or otherwise.

(vii) "Physician" means a person licensed to practice medicine or perform surgery or a licensed practitioner (including a nurse practitioner or Physician assistant) providing healthcare services or supplies if such services are directed and supervised by a Physician.

(viii) "Post-Service Claim" means a Health Plan Claim that is not required to be approved in advance of receiving health care services.

(ix) "Pre-Service Claim" means a Health Plan Claim that is required to be approved in advance of receiving health care services and that is not an Urgent Care Claim.

(x) "Urgent Care Claim" means a Health Plan Claim that is required to be approved in advance of receiving health care services and that requires a faster determination by the Claims Fiduciary because the time periods applicable to a Pre-Service Claim could seriously jeopardize the life or health of a claimant or the ability of such person to regain maximum function or would subject such person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the

claim. The Claims Fiduciary will determine whether a claim is an Urgent Care Claim applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; provided, however, that if a Physician with knowledge of the claimant's medical condition determines that the claim involves urgent care, the Claims Fiduciary will treat the claim as an Urgent Care Claim.

(b) Claims Procedures for Insured Programs. A claim for benefits under an Insured Program under the Plan and a request to review a denied claim thereof will be made using the claim procedures established under the separate agreements for those benefits. Notwithstanding the preceding sentence, any issue relating to the eligibility of a Covered Person for coverage under an Insured Program will be determined by the Plan Administrator.

(c) Claims Procedures for Self-Insured Programs.

(i) General. Any claim for benefits under a Self-Insured Program under the Plan, and a request to review the denial of such a claim under the Plan, will be submitted to the respective Claims Fiduciary for the Program pursuant to the remainder of this Section 4.7. In carrying out its responsibilities under the Program with respect to approving or disapproving claims for benefits and handling appeals of denied claims, the Claims Fiduciary of a Self-Insured Program will have the same authority and discretion that is granted to the Plan Administrator and its delegates under Section 4.2.

(ii) Claims for Benefits under Self-Insured Programs. A claim for benefits under a Self-Insured Program may be filed in writing with the Claims Fiduciary by a Covered Person or an Authorized Representative.

(iii) Timing of Response to Claims.

(A) Claims That Are Not Disability Claims or Health Plan Claims. This paragraph (A) applies to claims that are not Disability Claims (described in paragraph (B) below) or Health Plan Claims (described in paragraphs (C) – (G) below). Unless a claim is allowed in total, the Claims Fiduciary will notify a claimant of its determination no later than 90 days after the receipt of the claim. This 90-day period may be extended for an additional 90 days if the Claims Fiduciary determines the extension is necessary due to matters beyond the control of the Plan and notifies the claimant of the extension before the end of the initial 90-day window.

(B) Disability Claims. Unless a Disability Claim is allowed in total, the Claims Fiduciary will notify a claimant of its determination no later than 45 days after the receipt of the claim. This 45-day period may be extended twice for an additional 30 days if the Claims Fiduciary determines the extension is necessary due to matters beyond the

control of the Plan and notifies the claimant of the extension before the end of the initial 45-day window or the end of the first 30-day extension for the notice of the second extension. If the claimant has not furnished information that is necessary for determining the claim, the Claims Fiduciary will notify the claimant and describe the information that is needed. The claimant will be given a reasonable period of time, but not less than 45 days, in which to supply the missing information, and the Claims Fiduciary's deadline for responding to the claim will be tolled from the date on which notification is sent to the claimant until the date on which the claimant responds to the request for missing information.

(C) Post-Service Claims. The Claims Fiduciary will notify a claimant of its determination with respect to a Post-Service Claim, whether adverse or not, no later than 30 days after the receipt of the claim. This 30-day period may be extended for an additional 15 days if the Claims Fiduciary determines the extension is necessary due to matters beyond the control of the Plan and notifies the claimant of the extension before the end of the initial 30-day period. If the claimant has not furnished information that is necessary for determining the claim, the Claims Fiduciary will notify the claimant and describe the information that is needed. The claimant will be given a reasonable period of time, but not less than 45 days, in which to supply the missing information. While the Claims Fiduciary is waiting for the missing information, the deadline for responding to the claim will automatically be extended until 15 days after the claimant furnishes the missing information or, if the claimant does not furnish the missing information, until 15 days after the date for furnishing such information.

(D) Pre-Service Claims. The Claims Fiduciary will notify a claimant of its determination with respect to a Pre-Service Claim, whether adverse or not, no later than 15 days after the receipt of the claim. This 15-day period may be extended for an additional 15 days if the Claims Fiduciary determines the extension is necessary due to matters beyond the control of the Plan and notifies the claimant of the extension before the end of the initial 15-day period. If the claimant has not furnished information that is necessary for determining the claim, the Claims Fiduciary will notify the claimant no later than 5 days after receiving the claim and will describe the information that is needed. The claimant will be given a reasonable period of time, but not less than 45 days, in which to supply the missing information. While the Claims Fiduciary is waiting for the missing information, the deadline for responding to the claim will automatically be extended until 15 days after the claimant furnishes the missing information or, if the claimant does not furnish the

missing information, until 15 days after the date for furnishing such information.

(E) Urgent Care Claims. The Claims Fiduciary will notify a claimant of its determination with respect to an Urgent Care Claim, whether adverse or not, no later than 72 hours after the receipt of the claim. If the claimant has not furnished information that is necessary for determining the claim, the Claims Fiduciary will notify the claimant within 24 hours of receiving the claim and will describe the information that is needed. The claimant will be given a reasonable period of time, but not less than 48 hours, in which to supply the missing information. While the Claims Fiduciary is waiting for the missing information, the deadline for responding to the claim will automatically be extended until 48 hours after the claimant furnishes the missing information or, if the claimant does not furnish the missing information, until 48 hours after the time for furnishing such information has expired.

(F) Concurrent Care Claims. The Claims Fiduciary will notify a claimant of the denial, in whole or in part, of a Concurrent Care Claim in sufficient time before the reduction or termination of treatment to allow the claimant to appeal the denial with the Claims Fiduciary. In addition, if a claimant requests the Claims Fiduciary to extend a course of treatment beyond the approved period of time or course of treatment, and the claim involves urgent care (within the meaning of the term "Urgent Care Claim"), the Claims Fiduciary will notify the claimant of its decision within 24 hours of receiving the claim, provided the claimant made the claim at least 24 hours before the course of treatment was scheduled to terminate. If the claim involves urgent care and is made less than 24 hours before the course of treatment was scheduled to terminate, the claim will be treated as an Urgent Care Claim in accordance with paragraph (E) above.

(G) Errors in Submission. For Pre-Service Claims and Urgent Care Claims that name a specific claimant, medical condition and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing such claims, the claimant will be notified of the failure within 5 days (within 24 hours in the case of an Urgent Care Claim) and of the proper procedures to be followed. The notice may be oral unless the claimant requests written notification.

(iv) Notice of Benefit Denial.

(A) All Claims. If a claim for benefits is denied in whole or in part, the claimant will be notified in writing, and the written notice will contain the following information: (i) the specific reasons for the benefit denial; (ii) reference to the Plan provisions on which the denial is based; (iii) a description of any additional material or information necessary to perfect the claim and an explanation of why such information is necessary; and (iv) a description of the Plan's appeal process and applicable time limits (including the expedited process applicable to Urgent Care Claims) and a statement of the claimant's right to bring a civil action under ERISA section 502 following an adverse determination on appeal.

(B) Disability Claims. With respect to Disability Claims, in addition to the information specified in paragraph (A), such notice will also include: (i) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (3) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (ii) if the adverse benefit determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; (iii) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and (iv) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(C) Health Plan Claims. With respect to Health Plan Claims, in addition to the information specified in paragraph (A), such notice will also include: (i) if an internal rule, guideline, protocol or other similar criterion was relied on in denying the claim, a statement to that effect and a statement that a copy of the applicable rule, guideline, protocol or other similar criterion will be provided to the claimant, upon

request, free of charge; (ii) if the benefit denial was based on medical necessity or experimental treatment or a similar exclusion or limit, an explanation of such scientific or clinical judgment and its application to the claimant's medical circumstances; and (iii) except with respect to a claim under an Excepted Benefit Plan, (1) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings; (2) a description of the Plan's standard, if any that was used in denying the claim; (3) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and (4) a description of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman.

(v) Timing of Claimant's Appeal. If a claimant wishes to appeal the denial of all or part of a claim for benefits under the Plan, the claimant or an Authorized Representative must notify the Claims Fiduciary in writing before the time for filing the appeal expires, as follows:

(A) if the appeal did not involve a Disability Claim or Health Plan Claim, within 60 days after receiving notice of the denied claim;

(B) if the appeal involved a Disability Claim, within 180 days after receiving notice of the denied claim; or

(C) if the appeal involved a Health Plan Claim, within 180 days after receiving notice of the denied claim.

If such a notice is not timely given, the determination with respect to the claim shall be final and binding on all interested persons, subject to any right of the claimant to sue under ERISA section 502.

(vi) Appeals Process. The claimant's written notice of appeal should include the Company's name, the Covered Person's name, and should state in reasonable detail all of the grounds upon which the appeal is based, including references to applicable provisions of the Plan, and any issues or comments that are relevant to the claim. The claimant should supply any written comments, documents, records, or other information relating to the claim that he would like to be considered, whether or not submitted in connection with the initial claim. The claimant may also request copies of documents, records and other information relevant to the claim that are in the possession of the Plan, which will be provided to the claimant free of charge.

(A) Review of Disability Claim Appeal. A representative of the Claims Fiduciary may call the Covered Person or his health care provider to obtain medical records and/or other pertinent information. The Claims Fiduciary will review the denial of the claim without deference to the original decision of the Claims Fiduciary. The review will be conducted by an appropriate fiduciary who is neither the individual who denied the claim, nor the subordinate of such individual. If the denial of the claim was based in whole or in part on a medical judgment, the reviewer on appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who did not participate in the denial of the claim (and is not the subordinate of a health care professional who did participate in the claim denial). The reviewer on appeal will also identify any medical or vocational experts whose advice was obtained on behalf of the Plan in denying the claim, without regard to whether the Plan relied on such advice. Before the Plan can issue a denial of an appealed Disability Claim, as soon as possible and sufficiently in advance of the date of the notice of final adverse benefit determination, the Claims Fiduciary will provide the claimant, free of charge, (1) with any new or additional evidence considered, relied upon, or generated by the Plan (or at its direction) in connection with the claim, and (2) with any new or additional rationale on which the final adverse benefit determination is based, to give the claimant a reasonable opportunity to respond prior to the date the final adverse benefit determination is issued.

(B) Review of Health Plan Claim Appeal. A representative of the Claims Fiduciary may call the Covered Person or his health care provider to obtain medical records and/or other pertinent information. The Claims Fiduciary will review the denial of the claim without deference to the original decision of the Claims Fiduciary. The review will be conducted by an appropriate fiduciary who is neither the individual who denied the claim, nor the subordinate of such individual. If the denial of the claim was based in whole or in part on a medical judgment, the reviewer on appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who did not participate in the denial of the claim (and is not the subordinate of a health care professional who did participate in the claim denial). The reviewer on appeal will also identify any medical or vocational experts whose advice was obtained on behalf of the Plan in denying the claim, without regard to whether the Plan relied on such advice. If the claim that was denied was an Urgent Care Claim, the Claims Fiduciary will permit an expedited appeal in which the appeal may be made orally and all necessary information, including the Claims Fiduciary's decision on

appeal, may be transmitted between the claimant and the Claims Fiduciary by telephone, facsimile, or other similar method. In the case of a Health Plan Claim (other than a claim under an Excepted Benefit Plan), as soon as possible and sufficiently in advance of the date of the notice of final adverse benefit determination, the Claims Fiduciary will provide the claimant, free of charge, (1) with any new or additional evidence considered, relied upon, or generated by the Plan (or at its direction) in connection with the claim, and (2) with any new or additional rationale on which the final adverse benefit determination is based, to give the claimant a reasonable opportunity to respond prior to the date the final adverse benefit determination is issued.

(vii) Timing of Response to Appeals. The reviewer on appeal will issue its decision with respect to a claimant's appeal within the following timeframes:

(A) if the appeal did not involve a Disability Claim (described in paragraph (B) below) or Health Plan Claim (described in paragraphs (C) – (F) below), within 60 days after receiving the appeal, which may be extended for an additional 60 days if the Claims Fiduciary determines the extension is necessary due special circumstances and notifies the claimant of the extension before the end of the initial 60-day period;

(B) if the appeal involved a Disability Claim, within 45 days after receiving the appeal, which may be extended for an additional 45 days if the Claims Fiduciary determines the extension is necessary due special circumstances and notifies the claimant of the extension before the end of the initial 45-day period;

(C) if the appeal involved a Post-Service Claim, within 60 days after receiving the appeal;

(D) if the appeal involved a Pre-Service Claim, within 30 days after receiving the appeal;

(E) if the appeal involved an Urgent Care Claim, within 72 hours after receiving the appeal; or

(F) if the appeal involved a Concurrent Care Claim, before benefits terminate.

(viii) Notice of Appeal Denial.

(A) All Claims. If the determination on appeal is adverse to the claimant, the notice of determination on review will contain: (i) the reasons for its denial; (ii) reference to the specific Plan provisions

on which the benefit determination is based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents and other information relevant to the claim; and (iv) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to file a civil action under ERISA section 502(a).

(B) Disability Claims. With respect to Disability Claims, in addition to the information described in paragraph (A), such notice will also include: (i) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (3) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (ii) if the adverse benefit determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; (iii) either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist; and (iv) along with the statement of the claimant's right to file a civil action under ERISA section 502(a), a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

(C) Health Plan Claims. With respect to Health Plan Claims, in addition to the information described in paragraph (A), such notice will also include: (i) if a specific internal rule, guideline, protocol, or similar criterion was relied upon in making the adverse determination, a statement to that effect and a statement that a copy of the applicable rule, guideline, protocol or other similar criterion will be available to the claimant free of charge upon request; (ii) if a denied claim is based on medical necessity, experimental treatment, or similar exclusion or limit, an explanation of such scientific or clinical judgment and its application to the claimant's medical circumstances or a statement that such an explanation will be provided to the claimant free of charge; and (iii) except with respect

to a claim under an Excepted Benefit Plan, (1) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings; (2) a description and discussion of the Plan's standard, if any that was used in denying the claim; (3) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and (4) a description of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman.

(d) Deemed Exhaustion of Internal Claims Procedures.

(i) All Claims. Notwithstanding any provision in the Plan to the contrary, if the Plan does not follow applicable internal claims and appeals procedures, the claimant is deemed to have exhausted the internal claims and appeals process and may (A) pursue any available remedies under ERISA section 502(a), and (B) to the extent applicable for a Health Plan Claim, initiate an external review.

(ii) Disability Claims and Health Plan Claims. In the case of a Disability Claim or Health Plan Claim (other than a claim under an Excepted Benefit), the Plan generally must strictly comply with its claims and appeals procedures; provided, however, that this strict compliance requirement will not be violated, and the claims and appeals process will not be deemed exhausted, if the violation of such procedures is de minimis; does not cause, and is not likely to cause, prejudice or harm to the claimant; was for good cause or due to matters beyond the control of the Plan; and occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant (the "de minimis exception"). The claimant may request a written explanation of the violation from the Claims Fiduciary, and the Claims Fiduciary must provide such explanation within 10 days, describing why the violation should not cause the internal claims and appeals process to be deemed exhausted.

(A) With respect to a Disability Claim, if a court rejects the claimant's request for immediate review on the basis that the standards for the de minimis exception were satisfied, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the court's decision. Within a reasonable time after receipt of the court's decision, the Claims Fiduciary will notify the claimant of the resubmission of the Disability Claim.

(B) With respect to a Health Plan Claim, if an external reviewer or a court rejects the claimant's request for immediate review on the basis that the standards for the de minimis exception were satisfied,

the claimant has the right to resubmit and pursue internal review of the claim. Within a reasonable time (not to exceed 10 days) after the external reviewer or court rejects the claim for immediate review, the Claims Fiduciary will notify the claimant of the opportunity to resubmit the Health Plan Claim for internal review. Time periods for re-filing the claim will begin to run upon claimant's receipt of such notice.

(e) Language Services. The Claims Fiduciary will provide notices for a Disability Claims and Health Plan Claims (other than claims under Excepted Benefits) in a culturally and linguistically appropriate manner by (i) providing services that include answering questions and providing assistance with filing claims and appeals (including external review, to the extent applicable to a claim) in any applicable non-English language; (ii) providing, upon request, a notice in any applicable non-English language; and (iii) including in the English versions of all notices, a statement in any applicable non-English language indicating how to access the language services. With respect to an address in any county to which notice is sent, a non-English language is an "applicable non-English language" if 10% or more of the population residing in the county is literate only in that non-English language, as determined in guidance published by the Secretary of the Department of Labor.

(f) Nondiscrimination Requirement. The Claims Fiduciary will take such action from time to time as may be necessary to assure that all claims for eligibility and benefits made under this Section 4.7 are determined in accordance with the applicable Plan or Program documents and that the provisions of the applicable Plan or Program documents are applied consistently to similarly situated Covered Persons.

(g) Compliance with the Patient Protection and Affordable Care Act, as amended ("PPACA"). Notwithstanding the foregoing provisions of Section 4.7, claims and appeals with respect to Health Plan Claims shall be administered in compliance with the applicable requirements of PPACA and regulations issued thereunder, including PPACA's external review requirements.

4.8 Nondiscrimination Requirements.

If, in the judgment of the Plan Administrator, the Plan (or any Program thereunder) may fail to meet any of the nondiscrimination requirements of the Code (including, without limitation, Code sections 79, 105(h), 125, 129, or 9815 (incorporating the provisions of section 2716 of the Public Health Service Act)), or any regulations promulgated thereunder, the Plan Administrator may take such action as it deems appropriate to assure compliance with such requirements, and such action may be taken with or without the consent of any Participant and whether or not such action results in a forfeiture of Plan benefits. In furtherance of, but without limiting the foregoing, the Plan Administrator may treat the Plan as two or more separate plans solely for purposes of compliance with Code sections 105(h) or 9815 and the regulations thereunder, provided that the Plan Administrator designates the plans that are to be considered separately and the applicable provisions of each separate plan. A separate plan may be designated on the basis of eligible

Participants, benefits provided, Participant contributions required, or any other factors or combination of factors.

V. AMENDMENT OR TERMINATION

5.1 Amendment and Termination.

This Plan and the Programs are established with the intention of being maintained for an indefinite period of time. However, the Company reserves the right to amend the Plan, in whole or in part, at any time and from time to time, including, without limitation, (i) to amend any of the Programs or modify the benefits provided thereunder, (ii) to transfer any Program from the Plan into a separate unrelated plan, (iii) to merge another plan or benefit into the Plan, and (iv) to change one or more of the Program providers.

5.2 Termination.

The Company may discontinue or terminate the Plan, in whole or in part, at any time, including termination of any one or more of the Program.

VI. PARTICIPANT RIGHTS AND RESPONSIBILITIES AND LIMITATIONS THEREOF

6.1 No Enlargement of Employee Rights.

Nothing contained in this Plan or the Programs shall be deemed to give an Eligible Employee, Participant, or Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge or retire such person at any time.

6.2 No Assignment.

Except as may otherwise be specifically provided in this Plan, the Programs, or applicable law, a Participant's rights, interests or benefits under this Plan or the Programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the Programs, and any such attempt shall be void.

6.3 Subrogation and Recovery from Third Parties.

If a Participant incurs expenses that would be covered by the Plan on account of an injury, illness or condition caused by the actions or omissions of a Third Party or for which a Third Party is legally responsible, the Participant, by accepting benefits under the Plan agrees to repay the Plan and to the other terms described in this Section 6.3. Notwithstanding anything to the contrary herein, the terms of any insurance policy or summary plan description regarding the subject matter described in this Section 6.3, as well as in Sections 7.6, 7.7, and 7.9 hereof, may apply in lieu of or in addition to the provisions of such Sections.

(a) Definitions. When capitalized in this Section 6.3, these words and phrases have the following meanings:

(i) "Benefit Recipient" means any individual for whom benefits are paid by the Plan. If the Benefit Recipient is a minor, the obligations of the Benefit Recipient will be the obligations of his or her parent or guardian.

(ii) "Claimant" means a Benefit Recipient and his or her successors and assigns.

(iii) "Proceeds" means any money or other property that a Claimant recovers from a Third Party, including any recovery for medical expenses, attorneys' fees, costs and expenses, loss of consortium, pain and suffering, or noneconomic damages.

(iv) "Reimbursable Expenses" means any payment of benefits made under the Plan based on an illness or injury for which the Claimant may have a legal right to seek money or otherwise recover from any Third Party (less any amounts previously recovered by the Plan). "Reimbursable Expenses" includes the amount of all future benefits which may become payable under the Plan as a result of the illness or injury.

(v) "Third Party" means anyone from whom the Claimant may have a legal right to seek money or otherwise recover, including but not limited to:

(A) anyone alleged to have caused a Benefit Recipient to suffer illness, injuries, or damages;

(B) the insurer, guarantor, or any other indemnifier of anyone described in (A);

(C) anyone who may be obligated to provide benefits or payments to a Benefit Recipient, including for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners, or otherwise), or workers' compensation coverage; and

(D) anyone who may be liable to a Benefit Recipient on any equitable or legal liability theory.

(b) Right of Subrogation. Each Claimant assigns, transfers, and subrogates to the Plan all rights, claims, interests, and rights of action against a Third Party that they may have, to the extent of Reimbursable Expenses. Each Claimant is required to (i) inform the Plan of any claim or potential claim that they may have against any Third Party as of the date coverage under the Plan commences, or, if later, within 60 days of the act that is the source of the claim, if the claim is subject to this right of

subrogation; and (ii) notify the Plan before filing suit or settling any claim so the Plan may participate in the suit or settlement.

This subrogation right allows the Plan to pursue any claim that a Claimant has against any Third Party, whether or not the Benefit Recipient chooses to pursue that claim. The Plan is not obligated in any way to pursue this right independently or on the Claimant's behalf. The Plan is not obligated in any way to pay the Claimant part of any recovery that the Plan may get.

(c) Right of Reimbursement. In addition to any subrogation rights, each Claimant agrees to reimburse the Plan for Reimbursable Expenses from any and all Proceeds related to an injury or illness for which the Plan has paid benefits.

A constructive trust will be imposed on any Proceeds recovered, to the extent of Reimbursable Expenses. Each Claimant will serve as a constructive trustee over these Proceeds, which will be held in trust for the sole benefit of the Plan. Each Claimant agrees to hold the Proceeds separately and alone. Failure to comply is a breach of fiduciary duty to the Plan.

The Plan also has a first priority equitable lien against any rights a Claimant may have to recover Proceeds from a Third Party, to the extent of Reimbursable Expenses. This equitable lien will also attach to any Proceeds received by anyone (including, but not limited to, an attorney and/or a trust) when a Claimant exercises a right of recovery. The Plan may seek any other equitable remedy against any party that possesses or controls the Proceeds, including reasonable attorneys' fees.

(d) Obligations with Respect to the Plan's Rights. Each Claimant will cooperate fully with the Plan in asserting its rights, including: (i) providing any relevant information requested by the Plan; (ii) signing and returning all required documents; (iii) responding to requests for information about any accident or injuries; (iv) appearing at depositions and in court; and (v) getting the consent of the Plan before releasing any party from liability or payment of medical expenses.

Claimants will not accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval or otherwise prejudice the Plan's rights of subrogation and reimbursement.

Claimants agree to pay to the Plan the amount of Reimbursable Expenses from the first amounts received, regardless of whether the judgment, settlement, or other payment allocates any specified amount to medical expenses paid under the Plan, regardless of whether the Claimant has been completely compensated or made whole for their loss.

The Plan will not pay, and is not responsible for, a Claimant's attorneys' fees, court costs, experts' fees, filing fees, or any other costs or expenses of litigation (collectively, "litigation expenses"). Claimants must pay any litigation expenses. Claimants will not deduct any litigation expenses from the amount reimbursed to the Plan; any so-called "Fund Doctrine" or "Common Fund Doctrine" or

"Attorney's Fee Doctrine" does not override this right, and the Plan is not required to participate in or pay litigation expenses.

If the Benefit Recipient is a minor or is incapacitated, the Plan has no obligation to pay any medical benefits incurred due to an illness or injury caused by a Third Party until after the Benefit Recipient (or his/her authorized legal representative) gets valid court recognition, approval, and enforcement of the Plan's first dollar reimbursement and subrogation rights on all recoveries. If the illness or injury that initiates the Plan's reimbursement and subrogation rights involves the wrongful death of a Benefit Recipient, these provisions apply to the personal representative of the deceased Benefit Recipient.

If a Claimant does not comply with these requirements, the Plan may, in its sole discretion:

(i) offset any future Plan benefits that may become payable with respect to such Benefit Recipient by the amount not reimbursed;

(ii) obtain a court judgment against the Claimant for the amount that is not reimbursed and garnish or attach the Claimant's wages or earnings;

(iii) terminate the Benefit Recipient's coverage and coverage of the Benefit Recipient's family members; and

(iv) bring legal action against the Claimant.

Denial of any Plan expenses under this provision is subject to review under the Plan's claim review procedures.

6.4 Right to Necessary Information.

Any person claiming benefits under this Plan or any Program shall furnish to the Plan Administrator (or its delegate) any information requested to implement this Plan or the relevant Program.

6.5 Notice of Address.

Each person entitled to benefits under one or more Programs must file with the Company his or her mailing address and each change of mailing address. Any communication, statement or notice addressed to such person at such address shall be deemed sufficient for all purposes of this Plan and the Programs, and there shall be no obligation on the part of the Company, the Plan Administrator (or its delegate), or any insurer to search for or to ascertain the location of such person.

VII. GOVERNING TERMS AND APPLICABLE LAW

7.1 Severability.

If any provision of this Plan or any Program is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

7.2 Order of Application.

In determining and construing the provisions of the Plan applicable to any particular person or situation, the following shall be used in order of descending precedence:

(a) this Plan document, to the extent it addresses a matter not addressed in the applicable Summary Plan Description or to the extent it supplements or clarifies the applicable Summary Plan Description;

(b) the applicable Summary Plan Description;

(c) annual enrollment materials, as recognized for this purpose by the Plan Administrator ("Recognized Enrollment Materials");

(d) the Company's records for factual matters;

(e) the procedures, polices, and guidelines of the applicable Claims Fiduciary.

(f) the Plan Administrator's prior decisions and interpretations.

Notwithstanding the foregoing. Recognized Enrollment Materials shall take precedence over the applicable Summary Plan Description when:

(i) such Summary Plan Description has not yet been updated to reflect changes in benefits or procedures applicable to the period of coverage;

(ii) the Recognized Enrollment Materials have been updated for the applicable period of coverage; and

(iii) the Recognized Enrollment Materials describe a clear alteration of benefits or procedures relative to the applicable Summary Plan Description.

7.3 Corporate Actions.

Any action required to be taken by the Company under this Plan may be taken by any officer of the Company acting under authority of the board of directors as constituted from time to time, or comparable governing body charged with management of the organization, unless otherwise specified or delegated.

7.4 Titles and Headings.

The titles and headings of the sections of this document appear for convenience of reference only, and in the case of any conflicts, the text of this document, rather than the titles or headings, shall control.

7.5 Application of State Law.

This Plan shall be construed, administered, and enforced according to the laws of the State of Ohio, without regard to its choice of law provisions, to the extent such laws are not preempted by applicable federal law.

7.6 Right to Offset Future Payments.

In the event of an erroneous payment or payment amount, the Plan may reduce future benefits payable to or on behalf of such Participant by the amount of the error. This right to offset does not limit the Plan's right to recover an erroneous payment in any other manner.

7.7 Right to Recover Payments.

If the Plan pays an expense in a total amount exceeding the amount necessary to satisfy the Plan's obligation, the Plan may recover the excess directly from the person to or for whom the payment was made. If the Plan made payments based on fraudulent information, the Plan will exercise all available legal rights, including its right to withhold payment on future benefits until the overpayment is recovered. This right of recovery does not limit the Plan's right to recover an erroneous payment in any other manner.

7.8 Facility of Payment.

The Plan Administrator may pay the amount otherwise payable to a claimant to another person or institution it reasonably determines to be entitled to such payment if the claimant:

(a) dies before all Plan benefits have been paid;

(b) is a minor with no legal guardian;

(c) is incompetent or incapable of executing a valid receipt and without an appointed legal guardian or representative; or

(d) fails to give the Plan a forwarding address.

After making such payment to another person or institution, the Plan will have no further liability for the benefit payment.

7.9 Misrepresentation or Fraud.

A Participant who receives a Plan benefit as a result of false or incomplete information or a misleading or fraudulent representation must repay all amounts to the Plan and will be liable for

all collection costs including attorneys' fees and court costs. In addition, such Participant's coverage under the Plan may be immediately terminated.

7.10 Legal Action.

(a) Exhaustion of Administrative Procedures. Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan must first exhaust all claim, review, and appeal procedures provided by the Plan (and/or any HMO or insurance contract applicable to an Insured Program). No Employee or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

(b) Timing. To the fullest extent permitted by law, no such legal claim, action or proceeding described in (a) above may be brought more than one year after a final decision is provided under the Plan's claims and appeals procedures.

7.11 Gender and Number.

Whenever any words are used herein in the masculine gender, they will be construed as though they were also used in the feminine gender in all cases where they would so apply. Whenever any words used herein are in the singular form, they will be construed as though they were also used in the plural form in all cases where they would so apply.

7.12 Parties' Liability.

Neither the Company nor the Plan Administrator, nor any delegate thereof, will be liable for:

(a) good faith reliance on any fact or absence of fact, good faith action, or good faith omission;

(b) any other action or omission, except for willful misconduct, willful breach of duty to the Plan or gross negligence;

(c) another person's act or omission, unless required by law; or

(d) the tax consequences of contributions to or benefits paid from the Plan.

7.13 Disclaimer.

The Company makes no assertion or warranty regarding:

(a) healthcare services or supplies that a Participant receives as Plan benefits;

(b) whether Plan benefits will be excludable from a Participant's or Dependent's gross income for Federal or state income tax purposes;

(c) whether Plan benefits under the Insured Programs (including an HMO) will be paid by the applicable insurance company or HMO; or

(d) whether Plan benefits under the Self-Insured Programs will be paid in the event of the insolvency of the Company.

7.14 HIPAA Provisions.

This Section 7.14 contains the provisions required by the Standards for Privacy of Individually Identifiable Health Information contained in 45 CFR §164.102 et. seq. (the "Privacy Rules") and Security Standards for the Protection of Electronic Protected Health Information contained in 45 CFR §164.302 et. seq. (the "Security Rules"), each promulgated pursuant to Title II of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). The Privacy Rules relate to the permitted use and disclosure of protected health information ("PHI"), as that term is defined in the Privacy Rules, by the Programs that are health plans under HIPAA (referred to in this Section collectively as the "Health Plan") to the Company and/or to the Participating Employers (or any successor in interest thereto) (referred to together in this Section as the "Plan Sponsor"). The Security Rules relate to the security of PHI that is transmitted by electronic media or is maintained in electronic media ("Electronic PHI"), which is created, received, maintained, or transmitted on behalf of the Health Plan. Notwithstanding anything in this Plan to the contrary, the Health Plan shall be operated in accordance with HIPAA.

(a) Definitions. The following terms, when capitalized, will have the meanings set forth below for purposes of this Section, unless otherwise specified herein:

(i) "Electronic Protected Health Information" means Protected Health Information that is transmitted by electronic media or is maintained in electronic media.

(ii) "Health Information" means any information, whether oral or recorded in any form or medium, that is created or received by the Plan and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.

(iii) "Individually Identifiable Health Information" means Health Information, including demographic information and genetic information collected from an individual, that identifies an individual; or with respect to which there is a reasonable basis to believe the information can be used to identify an individual.

(iv) "Notice" means the notice of privacy practices for Protected Health Information required to be provided by the Plan to eligible Plan Participants pursuant to the Privacy Rules.

(v) "Plan Administration Functions" means administration functions performed by the Company on behalf of the Plan, but excluding functions performed by the Company in connection with any other benefit or benefit plan of the Company or any Participating Employer.

(vi) "Policies and Procedures" means those policies and procedures with respect to Protected Health Information established and maintained by the Plan pursuant to the Privacy Rules.

(vii) "Privacy Official" means that person designated by the Company to implement and enforce the Policies and Procedures.

(viii) "Protected Health Information" means Individually Identifiable Health Information that is transmitted by electronic media, maintained in any medium described in the definition of electronic media at 45 C.F.R. § 162.103, or transmitted or maintained in any other form or medium; provided, however, that Protected Health Information does not include Individually Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. § 1232g, records described at 20 U.S.C. § 1232g(a)(4)(B)(iv), and employment records held by a health plan in its role as employer.

(ix) "Required by Law" means a mandate contained in law that is enforceable in a court of law and includes, but is not limited to:

(A) court orders and court-ordered warrants;

(B) subpoenas or summons issued by a court, grand jury, governmental or tribal inspector general, or administrative body authorized to require the production of information;

(C) civil or authorized investigative demands;

(D) Medicare conditions of participation with respect to health care providers participating in the program; and

(E) statutes or regulations that require the production of information.

(x) "Settlor Functions" means those functions described in 45 C.F.R. § 164.504(f)(1)(ii)(A) and (B).

(xi) "Summary Health Information" means information that may be Individually Identifiable Health Information, and:

(A) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Company had provided health benefits under the Plan; and

(B) from which the information described at 45 C.F.R. § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

(b) Identity of Plan Sponsor.

(i) The Company shall be the plan sponsor for purposes of the Privacy Rules when performing Plan Administration Functions or Settlor Functions, when acting on behalf of the Plan with respect to its obligations under the Privacy Rules, and when acting on behalf of the Plan's Participants with respect to eligibility and participation.

(ii) The Privacy Official shall act for the plan sponsor, and shall be entitled to delegate its powers and responsibilities in accordance with its usual practices.

(iii) Individuals and classes of individuals identified in paragraph (g) of this Section shall assist the Privacy Official.

(c) Permitted Uses and Disclosure of Protected Health Information.

(i) Subject to obtaining written certification from the Company pursuant to paragraph (f), the Plan may disclose Protected Health Information to the Company only for the purpose of performing Plan Administration Functions or Settlor Functions. In addition, the Plan, or a health insurance issuer with respect to the Plan, may disclose to the Company information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan, and may disclose Summary Health Information to the Company, provided the Company requests Summary Health Information only for the purpose of:

(A) obtaining premium bids from health plans for providing health insurance coverage under or on behalf of the Plan; or

(B) modifying, amending, or terminating the Plan.

(ii) Notwithstanding any provisions of the Plan to the contrary, in no event will the Company be permitted to use or disclose Protected Health Information in a manner that is inconsistent with 45 C.F.R. § 164.504(f).

(d) Protected Health Information Disclosure Conditions. The Plan will disclose Protected Health Information to the Company only if the Company furnishes the certification set forth in paragraph (f) and the Company agrees that with respect to any Protected Health Information disclosed to it by the Plan or an insurer the Company will:

(i) not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as Required by Law;

(ii) ensure that any agents to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such Protected Health Information;

(iii) not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company or any Participating Employer;

(iv) report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(v) make Protected Health Information available to an individual who requests access to his or her Health Information in accordance with 45 C.F.R. § 164.524;

(vi) make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526;

(vii) maintain and make available information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

(viii) make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining compliance by the Plan with Subpart E of 45 C.F.R. § 164;

(ix) if feasible, return or destroy all Protected Health Information received from the Plan that the Company still maintains in any form, and retain no copies of such information, when no longer needed for the purpose for which the disclosure was made except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the destruction of the information infeasible; and

(x) ensure that the adequate separation between the Plan and the Company, required in 45 C.F.R. § 164.504(f)(2)(iii), is established.

(e) Company Certification. The Plan (or a health insurance issuer with respect to the Plan) will disclose Protected Health Information to the Company only upon the receipt of a certification from the Company that the Plan has been amended to incorporate the provisions of 45 C.F.R. § 164.504(f)(2)(ii), and that the Company agrees to the conditions set forth in paragraph (f) of this Section.

(f) Adequate Separation Between the Plan and the Company. The Company will allow only the Privacy Officer and the following classes of employees ("Authorized Employees") access to Protected Health Information:

(i) Employees of the Company's Human Resources Benefits group who receive Protected Health Information in the ordinary course of business; and

(ii) Employees appointed to perform the duties of the Plan Administrator.

Only these specified employees will have access to and use Protected Health Information to the extent necessary to perform the Plan Administration Functions that the Company performs for the Plan.

(g) Disciplinary Sanctions and Mitigation of Harm. In the event that any employee specified in paragraph (f) above does not comply with the provisions of this Section 7.14, that employee will be subject to disciplinary action by the Company (which may include termination) for such non-compliance, as set forth in the Policies and Procedures. In addition, the Plan will take all necessary action to mitigate any harm caused by an employee's failure to comply with the provisions of this Section.

(h) Compliance with Health Privacy Laws. To the extent applicable, the Plan will comply with Subpart E of 45 C.F.R. § 164 and any other applicable federal, state and local laws governing the safeguarding of health privacy matters.

(i) Interpretation of HIPAA Privacy Rules. The provisions of this Section are meant to comply with (and not expand upon) the requirements of the HIPAA Privacy Rules and shall be interpreted accordingly. In the event that any of the provisions of this Article are not applicable to the Plan, are superseded, or are no longer required under HIPAA, they shall be deemed to be deleted from the Plan and shall have no further force or effect.

(j) Security of Electronic Protected Health Information. The Plan will disclose Protected Health Information to the Company only if the Company agrees with respect to any Electronic Protected Health Information, that the Company will:

(i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan;

(ii) ensure that the adequate separation required by the HIPAA Privacy Rules and as set forth in 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(iii) ensure that any agent to whom the Company may provide this information agrees to implement reasonable and appropriate security measures to protect the information; and

(iv) report to the Plan any security incident of which the Company becomes aware.

IN WITNESS WHEREOF, the Company has caused this Plan to be executed by its duly authorized officer as of the 12/18/2020 day of December, 2020.

THE LINCOLN ELECTRIC COMPANY

By: DocuSigned by: Michele Kuhrt A4CB896DF7E64AC...

Title: Executive Vice President, Chief Human Res

SCHEDULE A – PROGRAMS

1. Anthem BCBS Medical– Self-Insured Program
2. BCBS of TN Medical – Insured Program
3. CIGNA International Medical – Insured Program
4. Caremark Prescription Drug – Insured Program
5. MetLife Dental – Insured Program
6. Humana Dental – Insured Program
7. EyeMed Vision – Insured Program
8. Health Care Flexible Spending Account Program – Self-Insured Program
9. MetLife Life Insurance Program – Insured Program
10. MetLife Accidental Death and Dismemberment Insurance – Insured Program
11. MetLife Short-Term Disability Insurance – Insured and Self-Insured Program
12. MetLife Long-Term Disability Insurance Program – Insured Program

SCHEDULE B – PARTICIPATING EMPLOYERS

1. J.W. Harris Co., Inc.
2. Lincoln Global, Inc.
3. Welding, Cutting, Tools & Accessories, LLC
4. Smart Force, LLC
5. Easom Automation Systems, Inc.
6. Tennessee Rand, Inc.
7. ProSystems, LLC
8. Coldwater Machines, LLC
9. Weartech International, Inc.
10. Vizient Manufacturing Solutions, Inc.
11. Wayne Trail Technologies, Inc.
12. Wolf Robotics, LLC
13. Rimrock Corporation
14. The Lincoln Electric Company