Prepared by:
Hitesman & Wold, P.A.

WELFARE BENEFIT PLAN FOR EMPLOYEES OF
COMMERCIAL METALS COMPANY

including as components:
Commercial Metals Company Medical Plan
Commercial Metals Company California Medical Plan
Commercial Metals Company Hawaii Health Plan
Commercial Metals Company Dental Plan
Commercial Metals Company Vision Plan
Commercial Metals Company Basic Life and AD&D Plan
Commercial Metals Company Voluntary Life and AD&D Plan
Commercial Metals Company Short Term Disability Plan
Commercial Metals Company Long Term Disability Plan
Commercial Metals Company Healthcare Flexible Spending Account
Commercial Metals Company Critical Illness, Accident, and Hospital Indemnity Benefit Plan
Commercial Metals Company Employee Assistance Plan
Commercial Metals Company Business Travel Accident Plan

Amended and Restated Effective January 1, 2023

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GENERAL INFORMATION

Name of Plan:	Welfare Benefit Plan for Employees of Commercial Metals Company
ERISA Plan Number:	501
Employer:	Commercial Metals Company 6565 North MacArthur Boulevard Irving, TX 75039 Phone: 214.689.4300
Federal Employer Identification Number:	75-0725338
Plan Administrator:	Commercial Metals Companies Investment and Benefits Administrative Committee 6565 North MacArthur Boulevard Irving, TX 75039 Phone: 214.689.4300
Agent for Service of Legal Process:	Commercial Metals Company Attn: Legal Department 6565 North MacArthur Boulevard Irving, TX 75039 Phone: 214.689.4300 Legal process may also be served on the Plan Administrator.
Type of Participants covered under the Plan:	All Eligible Employees of the Employer.
Plan modifications:	Any amendments to or termination of the Plan will be accomplished by, or pursuant to, a written resolution of the Plan Sponsor.
Plan Year:	January 1 through December 31

Carrier Phone Numbers and Websites

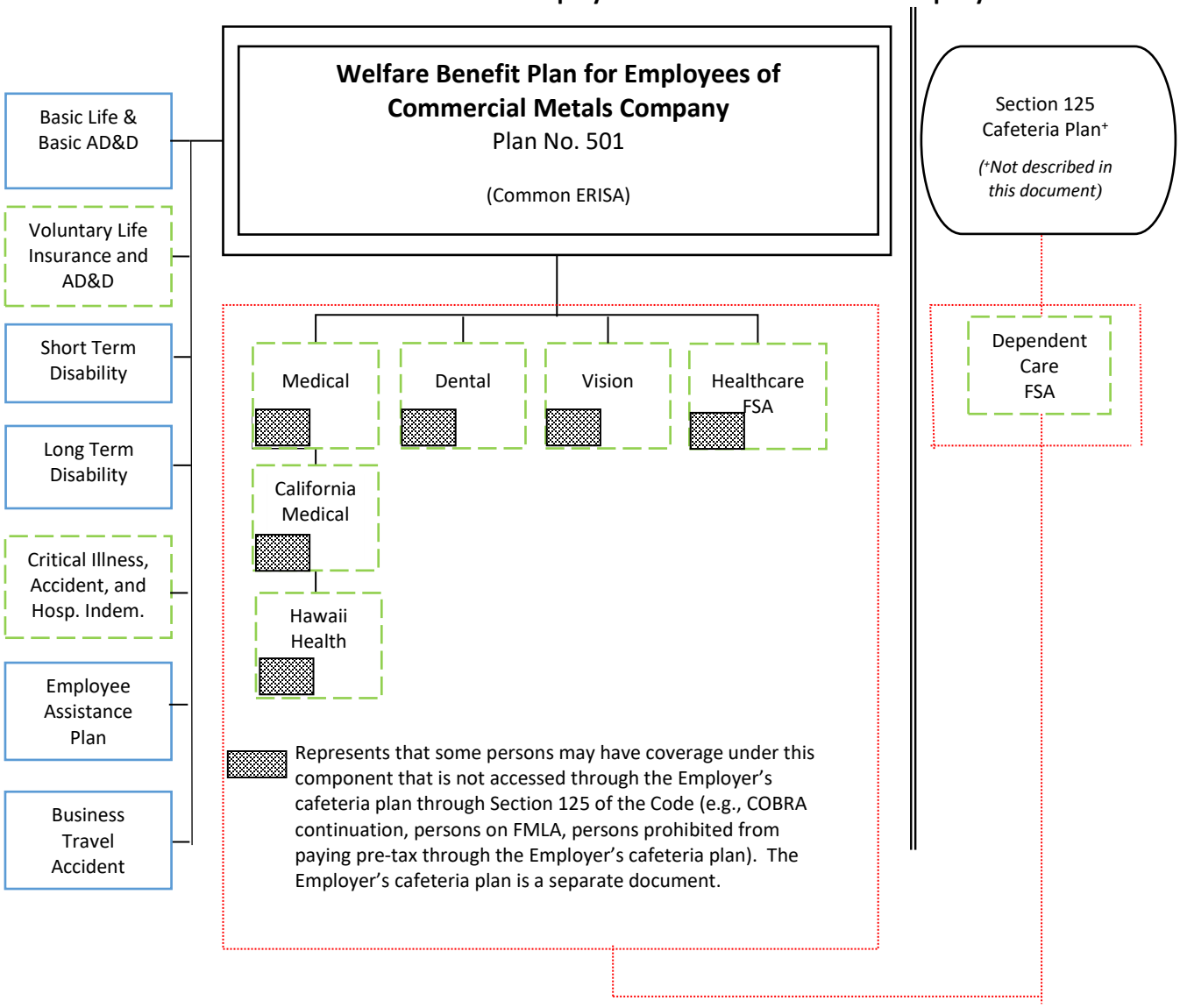
If you have questions or need additional information about your benefits, contact the resources shown below:

Plan Contact Information			
Plan	Insurance Company/ Claim Administrator	Phone/Website	Claims Address
Medical	Blue Cross and Blue Shield of Texas Group #: 009123	1.877.262.7977 www.bcbstx.com Customer Service Helpline Monday – Friday, 8 a.m. – 8 p.m. (CST) Medical Preauthorization Helpline Monday – Friday, 7:30 a.m. – 6 p.m. (CST) 1.800.441.9188 Mail Order: Express Scripts Home Delivery P.O. Box 66577 St. Louis, MO 63166-6577 www.express-scripts.com/rx 1.833.715.0942 Nurse Helpline 24 hours a day/7 days per week 1.800.581.0368 Mental Health and Chemical Dependency Preauthorization Helpline Monday – Friday, 8 a.m. – 6 p.m. (CST) 1.800.528.7264	Medical Claims Blue Cross and Blue Shield of Texas Claims Division P.O. Box 660044 Dallas, TX 75266-0044 Retail: Prime Therapeutics P.O. Box 25136 Lehigh Valley, PA 18002-5136
	Kaiser Permanente HMO (CA only) Northern California Group #: 602827 Southern California Group #: 101708	1.800.464.4000 www.kaiserpermanente.org	Northern California (Group #: 602827) KFHP California Claims Administration P.O. Box 12923 Oakland, CA 94604-2923 Southern California (Group #: 101708) Kaiser Permanente Claims Administration Department P.O. Box 7004 Downey, CA 90242-7004

	HMSA (HI Only) Group #: 29482	1.800.776.4672 www.hmsa.com	Medical Claims (HCFA 1500) P.O. Box 44500 Honolulu, HI 96804-4500 Dental Claims P.O. Box 1320 Honolulu, HI 96807-1320 Drug Claims CVS Caremark PO Box 52136 Phoenix, AZ 85072-2136 Hospital Claims (UB-92) P.O. Box 32700 Honolulu, HI 96803-2700
Dental	Delta Dental Group #: 5838	1.800.521.2651 www.deltadentalins.com	Delta Dental Insurance Company P.O. Box 1809 Alpharetta, GA 30023-1809
Vision	Vision Service Plan Group #: 12247388	1.800.877.7195 www.vsp.com	Vision Service Plan Claims Services P.O. Box 385018 Birmingham, AL 35238 – 5018
Telehealth	MD Live Group #: 009123	24 hours a day/7 days a week 1.888.680.8646 www.mdlive.com/bcbstx	Not applicable
	Kaiser (CA Only) Northern California Group #: 602827 Southern California Group #: 101708	24 hours a day/7 days a week 1.800.464.4000 www.kp.org/myhealth	Not Applicable
	HMSA (HI Only) Group #: 29482	24 hours a day/7 days a week 1.866.939.6013 www.hmsaonlinecare.com	Not applicable
Basic & Optional Life, AD&D	Lincoln Financial Group #: 09-466376	1.844.829.5510 www.MyLincolnPortal.com	Contact CMC Employee Services
Short Term Disability	Lincoln Financial Group #: 09-466376	1-844-829-5510 www.MyLincolnPortal.com	Contact CMC Employee Services
Long Term Disability	Lincoln Financial Group #: 09-466376	1.844.829.5510 www.MyLincolnPortal.com	Contact CMC Employee Services
Health Care FSA Dependent Care FSA LifeStyle Benefit	HealthEquity Group #: 24699	1.877.924.3967 www.healthequity.com	HealthEquity, Claims Administrator P.O. Box 14053 Lexington, KY 40512 Or via facsimile to: 1.877.353.9236
Critical Illness, Group Accident and Hospital Indemnity	VOYA Group #: 70288-9	1.877.236.7564 www.presents.voya.com/EBRC/cmc	Contact CMC Employee Services
Employee Assistance Program	SupportLinc Group #: cmc	24 hours a day/7 days a week 1.888.881.5462 www.supportlinc.com Username: cmc (all lowercase)	Not applicable

Business Travel Accident	STARR ASSIST Group #: cmc	1.800.667.7222 (U.S.) 1.416.977.8687 (Outside U.S.) assistance@wtp.ca	Contact CMC Employee Services
COBRA Administrator	bswift COBRA Group #: cmc	1.866.365.2413 https://benefitsbilling.bswift.com	bswift COBRA P.O. Box 2758 Omaha, NE 68103-2758
Questions contact CMC Employee Services | 1.877.262.8050 | employeeservices@cmc.com			

ILLUSTRATION 1: Welfare Benefit Plan for Employees of Commercial Metals Company



LEGEND:

Employer Paid Benefit – The Employer provides certain core benefits to you automatically – you do not need to enroll for coverage. The Employer pays the full cost of these core benefits.

Employee Contribution(s) Required – These benefits are optional. To be covered under optional benefits, you must enroll for coverage and pay contributions.

Pre-Tax deduction

Contributions are withheld from your pay as soon as administratively practical after coverage under a Component becomes effective.

PART I.
GENERAL INFORMATION ABOUT THE PLAN

1.1 What is the purpose of the Plan and this document?

The purpose of the Plan is to provide certain Employees with an opportunity to receive certain benefits as part of a single employee welfare benefit plan, as further described herein. You are being provided this document to give you an overview of the Plan and to address certain information that may not be addressed in the Exhibits.

1.2 When did, the Plan take effect?

The Employer amended and restated the Plan effective January 1, 2023. The Plan operates on a "Plan Year" running from the first day of January through the last day of December.

1.3 Who can participate in the Plan?

Each Employee of the Employer shall be eligible to participate in the Plan upon meeting the eligibility requirements (e.g., hourly work requirements, etc.) of any one of the applicable Components identified in Exhibits B through L. These employees are called "Eligible Employees." Those Eligible Employees who participate in one or more of the Components of the Plan are called "Participants." There are certain exceptions. They are described in the underlying Plan document.

In general, and subject to the eligibility requirements specified in the Exhibit applicable to a Component, you will be eligible to participate in the Plan if you are:

- Employed by Commercial Metals Company,
- A domestic Employee who:
  - Is regularly scheduled as a full-time Employee,
  - Is on the Employer's United States payroll, and
  - Resides in the United States

If you are an Employee working for the Employer in Hawaii, you are eligible to participate in the Plan if you are working twenty or more hours per week for four (4) consecutive weeks, regardless of your employee class (e.g., full-time, part-time, or intern).

"**Employee"** means a common-law employee of the Employer, except that the term "Employee" does not include any common-law employee who is a leased employee (including, but not limited to, an individual defined in Internal Revenue Code § 414(n)), or any common-law employee who is an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is on the Employer's W-2 payroll. The term "Employee" also does not include any individual who performs services for the Employer but who is paid by a temporary or other employment agency or any employee covered under a collective bargaining agreement unless the collective bargaining agreement so provides. The term "Employee" includes "former employees" for the limited purpose of allowing continued eligibility for benefits as provided hereunder after an employee ceases to be employed by the Employer.

1.4 Effective Date of Coverage.

The following table shows the dates on which coverage becomes effective under a Component begins based on events that provide opportunities to enroll for coverage or change coverage elections. Notwithstanding the following, coverage may be delayed in certain circumstances as further described in the *Effective Date of Coverage Delays* provision and/or provided in the applicable Coverage Contract.

Effective Date of Coverage for Selected Events

Note: Notwithstanding the foregoing, the effective date of coverage for the following populations is as follows:

Benefit Plan	Benefit Eligible New Hires	Qualified Life Event	Open Enrollment
	For plans that require enrollment, enrollment must occur within 31 days of your date of hire	Elections must be made within 31 days of the Qualified Life Event	Elections must be made during an Open Enrollment period
Medical, Vision, Dental	Date of hire	First of month following date of qualified life event.	January 1 following Open Enrollment period
Health Care FSA and Dependent Care FSA	Date of hire	First of month following date of qualified life event.	January 1 following Open Enrollment period
Basic Life, Basic AD&D	Date of hire	Not applicable	Not applicable
Short Term Disability	Date of hire	Not applicable	Not applicable
Long Term Disability	Date of hire	Not applicable	Not applicable
Optional Life	Date of hire	First of month following date of qualified life event.	January 1 following Open Enrollment period
Optional AD&D	Date of hire	First of month following date of qualified life event.	January 1 following Open Enrollment period
Business Travel Accident	Date of hire	Not applicable	Not applicable
Employee Assistance Program	Date of hire	Not applicable	Not applicable
Critical Illness, Accident, and Hospital Indemnity	Date of hire	First of month following date of qualified life event.	January 1 following Open Enrollment period

- Hawaii benefit eligible new hires coverage is effectivethe first of the month following four (4) consecutive weeks of employment.

Note: If an election requires evidence of insurability, coverage will not become effective until approval is received from the insurance company. Newborn and adopted children who are enrolled timely will have their coverage effective date coincide with the date of the event.

1.5 Effective Date of Coverage Delays.

Coverage will not become effective unless you are otherwise eligible for coverage under the Component. For example, medical coverage would not be effective on the date of a qualified life event if the change occurs before you have completed your initial eligibility period. In no event will your dependent's coverage become effective until you become covered under the applicable plan.

Actively at Work and Confined for Care Requirements

For all Components except the Medical Plan, an effective date of coverage will also be delayed in the following circumstances:

- For you, if you are not actively at work on the day your coverage would otherwise become effective.
- For your dependent, if he/she is confined for care on the day his/her coverage would otherwise become effective.

Actively at Work	Being actively at work means that you are performing the essential duties of your regular occupation at the time and place duties are normally performed, as assigned by the Employer. The actively at work requirement does not apply if the effective date of coverage coincides with a scheduled day off, including a vacation day or an Employer-recognized holiday, if you are actively at work immediately preceding and immediately following the scheduled day off.
Confined for Care	Except in the case of a newborn child, confined for care refers to a dependent who is: • An inpatient in a hospital, hospice, rehabilitation center, convalescence center, or custodial care facility, or • Confined at home under the care of a physician.

If you are not actively at work, your effective date of coverage will be delayed until you return to work for one full day. If your dependent is confined for care, his/her effective date of coverage will be delayed until he/she is released from confinement. These delays also apply to increases in insurance amounts under the long-term disability, life, and AD&D plans.

Evidence of Insurability

The Life Insurance Plan further restricts effective dates of coverage for certain insurance amounts based on evidence of insurability. Refer to the Life Insurance Plan's Coverage Contract for further information.

1.6 Can others be covered through me?

Depending upon the terms and conditions of a particular Component, you may be able to have certain family members (e.g., child, spouse, etc.) covered through you. In order for other persons to be covered through you, you must be (and remain) a Participant in the Plan and under the particular Component(s).

Eligible dependents are your:

- Legal spouse, including a same-gender spouse, or a common-law spouse.
- Domestic Partner
- For the medical, dental, vision, and life insurance and AD&D benefits: Children married and unmarried up to age 26.
    - Natural children
    - Stepchildren
    - Legally adopted children
    - Foster children
    - Children of your common-law spouse
    - Children of your domestic partner
    - Children for whom you have legal guardianship

Your unmarried dependent children who are age 26 or over and physically or mentally incapable of self-support may continue coverage beyond age 26 if they are medically certified as disabled and remain unmarried, totally incapacitated, and dependent on you for support. Contact Employee Services via email at employeeservices@cmc.com or call 1.877.262.8050.

Special guidelines apply when covering a common-law spouse or the child of a common-law spouse. Generally, you and your common-law spouse must both be age 18 or over, not related by blood in a way that would prevent you from being married to each other and have a relationship that would require a divorce to dissolve.

Special guidelines and tax implications apply when covering a domestic partner or the child of a domestic partner. Generally, you and your domestic partner must both be age 18 or over, and you and your domestic partner must be each other's sole domestic partner, not related by blood in a way that would prevent you from being married to each other and assume mutual obligations for the welfare and support of each other.

With respect to Components that are group health plans, the Plan extends benefits to an Employee's non-custodial child as required by any qualified medical child support order (QMCSO) under ERISA §609(a). The Plan has procedures for determining whether an order qualified as a QMCSO.

Dependents are not eligible if they are on active duty in the military service of any country or if you are not enrolled for coverage.

Any documentation that you are required to provide to establish a dependent's eligibility for coverage under a Component must be submitted through the Employer's Benefits Service Center

Note: **Promptly Report a Dependent's Loss of Eligibility.** No credit or refund of contributions will be made in the event of failure to notify the Employer of a dependent's loss of eligibility. It is important that you always notify Employee Services office promptly when a dependent no longer meets eligibility requirements (e.g., due to divorce). Failure to do so may result in your payment of contributions for a dependent that is not covered, as the dependent's coverage will be cancelled retroactive to the date he/she was no longer eligible. In addition, if any benefit payments are made for or on behalf of that dependent after he/she is no longer eligible, you will be responsible for reimbursement.

Note: With the exception of life insurance, no one may be covered under the Plan as both an Employee and a dependent. For example, if your spouse/domestic partner/common-law spouse is covered as an Employee under basic life insurance, you may also cover your spouse/domestic partner/common-law spouse as a dependent under dependent life insurance. However, you both work for the Employer, either of you, but not both of you, can elect to cover your eligible dependent children.

1.7 What are the conditions of participation?

As a condition of participation and receipt of benefits under the Plan, you agree to:

(a) observe all Plan rules and regulations;

(b) consent to inquiries by the Plan with respect to any provider of services involved in a claim under the Plan;

(c) submit to the Plan all notifications, reports, bills, and other information that the Plan may reasonably require;

(d) agree to repay any overpayments or incorrect payments received through the Plan; and

(e) agree to provide required proof or documentation regarding eligibility.

Failure to do so may impact your ability to participate in the Plan (including the Components).

1.8 When does participation end?

Voluntary Cancellation of Coverage

You may cancel coverage only during an Open Enrollment period unless you experience a qualified life event, as summarized in Section 1.11. If you elect cancellation within 31-days following the date of a qualified life event, the effective date of cancellation will be as summarized in that provision. Otherwise, the effective date of cancellation will be the January 1 immediately following the Open Enrollment period during which you elect to cancel your coverage.

Certain benefits are provided by the Employer at no cost to you and you may not voluntarily cancel coverage. These benefits are short term disability, long term disability, basic life insurance, basic accidental death & dismemberment insurance, EAP and business travel accident insurance.

Involuntary Termination of Coverage

Participation in the Plan ends upon your termination of employment. The following table shows the dates on which coverage terminates under the Components following your termination of employment:

Plans	When Coverage Terminates
Medical Dental Vision Employee Assistance Program	Last day of the month in which the Participant is no longer employed by the Employer
Life AD&D Short Term Disability Long Term Disability Business Travel Accident Health Care, Dependent Care FSA Critical Illness/Accident/Hospital Indemnity	Last day on which the Participant is actively employed by the Employer

Coverage under the Plan will also terminate immediately on the earliest of:

- The date on which you no longer meet the eligibility requirements.
- The last day of the month in which employment ends for any reason including a strike, work slowdown, or lockout. (Exceptions apply for certain leaves of absence and for the short and long term disability coverage as further provided in the Coverage Contracts for those Components.)
- The end of the last month for which you made any required contribution for coverage.
- The date on which coverage for your employee group or class is discontinued.
- The date on which the Plan or a Component terminates.

Furthermore, there are other situations (e.g., fraud) in which coverage may be terminated retroactively (i.e., rescinded) when allowed by applicable law.

Coverage for a dependent will terminate immediately on the earliest of:

- The date on your coverage terminates.

- The end of the last month for which you made any required contribution for coverage.
- The date on which the Component no longer provides dependent coverage.

1.9 Does participation end during a leave of absence?

You may be eligible to continue coverage under the Components listed below. Contact Employee Services via EmployeeServices@cmc.com or 1.877.262.8050.

- Medical
- Vision
- FSA - Health Care / Dependent Care
- Dental
- Voluntary Life & Accidental Death and Dismemberment
- Critical Illness / Accident / Hospital Indemnity

Coverage for a dependent will terminate on the date on which your coverage terminates.

If coverage terminates during your leave of absence, you may be able to continue certain coverage through COBRA or conversion and portability provisions as permitted under the Component.

If coverage terminates during your leave of absence, special enrollment rules apply when you return to work. Generally, your benefit elections in effect on the day your coverage terminated will be reinstated if you return to work:

- Within 31 days following the date your leave of absence began, and
- During the same calendar year in which your leave of absence began.

In this case, you may not change your previous benefit elections until the next Open Enrollment period unless during your leave of absence:

- An Open Enrollment was held. In this event, you would be able to make new elections. Your previous elections would be reinstated through the remainder of the current calendar year and your new elections would take effect on the following January 1.
- You experienced a qualified life event. For example, if you married, you would be able to add coverage for your new spouse/domestic partner/common-law spouse.
- You experienced an event that would make you eligible for special enrollment. For example, if you had previously declined CMC medical coverage because you had other health coverage and that coverage ended.

Note: Refer to Section 1.11 for information on limitations that apply to Open Enrollment, qualified life event, and special enrollments.

If you return to work more than 31 days following the date your leave of absence began or in a subsequent calendar year, you will be required to make new enrollment elections when you return to work.

1.10 How do I enroll and make benefit elections or changes?

The Employer, in its capacity as Plan Administrator, will provide you with a website address to enroll and make elections or changes for the Components identified in Exhibits B through L, including information about the costs of the various Component benefits. For additional information regarding enrollment and benefit elections for a Component identified in Exhibits B through L, please read the information contained within the Exhibits of the particular Component(s).

How to Enroll (New Hire/Status Change)

- Contact Employee Services at 1.877.262.8050.
- From the CMC GlobalNet homepage. Click on "Benefits" on the right to get started. For GlobalNet password resets, contact the IT Helpdesk at 1.888.823.1212.
- Go to cmcbenefits.bswift.com. You'll need your Employee Number to enroll the first time you log in.
- From myCMCBenefits.com click on "Enroll Now"

Enrollment Deadline

You have a certain timeframe during which you can enroll or make changes for yourself and your eligible dependents for coverage under the Plan. This period is referred to as the "eligibility period." The eligibility period begins on your first day of employment.

Enrollment Rules for Rehired/Reinstated Employees

Special enrollment rules apply if you terminate employment and are then rehired. Generally, your benefit elections in effect on the date of your termination will be reinstated if you are rehired:

- Within 31 days following the termination date, and
- During the same calendar year in which the termination occurred.

If you leave the Employer and are rehired within 31 days, your benefits begin as of the date you are rehired. The Employer will reinstate the benefits you had in place as of your date of termination.

Note: Refer to Section 1.11 for information on limitations that apply to open enrollment, qualified life event, and special enrollments.

1.11 Can I change my election in a Component of the Plan during Plan Year?

Whether a change in coverage under a particular Component can occur during the Plan Year depends upon the terms and conditions (1) of the Component, and (2) to the extent you pay for any portion of the cost of coverage on a pre-tax basis, the Employer's cafeteria plan under Section 125 of the Code (reflected in a separate document).

You make benefit elections (enrolling for coverage, electing dependent coverage, insurance amounts, declining coverage, etc.) when you are first eligible to enroll. Once you make elections, you may change them only during open enrollment periods unless you experience a qualified life event or become eligible for a special enrollment. Certain changes are subject to the *Effective Date of Coverage Delays* provision.

Note: If you decline enrollment for yourself or your dependents (including a spouse/domestic partner/common-law spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in certain Components if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage). Also, if you acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. You must request this new enrollment within 31 days of the loss of coverage, marriage, birth, adoption, or placement for adoption. These special enrollment rights are further described in the Exhibits and Coverage Contracts of the Components that are subject to these rules.

Open Enrollment Periods

The Employer schedules Open Enrollment periods once each year (usually in the Fall). During an Open Enrollment period, you may enroll or make changes to your optional benefits. See Illustration 1 for list of optional benefits.

Your Open Enrollment elections become effective on the January 1 following the Open Enrollment period subject to the *Effective Date of Coverage Delays* provision.

Special Enrollment Procedure

If you wish to make changes to your coverage you must do so within 31 days of the special enrollment event via the benefits service center or contact Employee Services.

Special Enrollment Assistance – Eligible Individuals

If you are eligible for the Employer's health coverage, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer- sponsored health coverage, but need assistance in paying their health premiums.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office, call 1.877.KIDS NOW, or go online to www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer- sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, our health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in this plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

1.12 What happens when there is an insurance company refund?

Any refund provided to the Employer by an insurance company that has issued an insurance contract for any Component provided under the Plan will be allocated in accordance with the then prevailing United States Department of Labor (DOL) guidance. As a Participant in the Plan, you may directly benefit from such a refund. The portion of the refund allocated to Participants will be (a) used solely for the benefit of the Participants participating in the Component with respect to which the refund was provided, and (b) returned to such Participants in a manner allowed by applicable law (e.g., to provide a refund, a premium holiday, an increase in benefits, etc.), as determined by the Plan. The portion of the refund allocated to Participants will be returned to the Participants no later than three (3) months following the date on which the Employer receives such refund from the insurance company.

1.13 How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan (including each of the Components) indefinitely, the Employer has the right to amend or terminate the Plan in whole or in part at any time. It is also possible that future changes in state or federal laws may require that the Plan be amended or terminated accordingly. You will be informed if changes are made to the Plan.

1.14 How are claims determined?

ERISA requires certain rules to be followed regarding the determination of claims for benefits (e.g., format, time frames, notifications, etc.). What rules apply in a particular situation depend upon a variety of factors (including the type of benefit, whether it is provided on an insured or self-insured basis, etc.). The underlying Plan document provides the overall structure for determining claims while many of the specifics of the particular Component are described in Exhibit M and/or the Coverage Contract relating to that Component. It is intended that the claims procedures be in conformance with the applicable ERISA requirements.

Special note regarding the Medical Plan Component. With respect to the Commercial Metals Company Medical Plan, Commercial Metals California Medical Plan, and Commercial Metals Company Hawaii Health Plan Components of the Plan, the Patient Protection and Affordable Care Act ("PPACA") also requires certain rules to be followed. The specifics of these rules and their application to the previously listed Components of the Plan are described in the Plan document and in Exhibit M and the Coverage Contract for that Component (and subsequent changes to that Exhibit and the Coverage Contracts). It is intended that the claims procedures be in conformance with the applicable PPACA requirements.

1.15 Does the Plan have subrogation rights?

In addition to any rights regarding subrogation and reimbursement described in the Coverage Contracts, you or someone covered through you incurs expenses covered under, or receives benefits under, the Plan with respect to an injury or illness for which a third party (or its insurer) may be liable, the Plan retains all rights, including first right of subrogation, recovery, and reimbursement as set out more specifically in the Coverage Contracts. Separate and apart from the Plan's right of subrogation, the Plan shall have a first lien and right to reimbursement. The Plan's first lien supersedes any right that you may have to be "made whole" and the Plan precludes the application or operation of the "made-whole," "attorney-fund," "common-fund," or any similar doctrines. By participating in the Plan, you agree to do nothing to prejudice or oppose the Plan's right to subrogation and reimbursement, and you acknowledge that the Plan precludes operation of the "made-whole," "attorney-fund," "common-fund," or any similar doctrines.

1.16 Can I assign my right to benefits under the Plan?

No Participant or his or her dependent or other beneficiary may at any time, either while covered under the Plan or following termination of coverage, assign his or her right to sue to receive benefits under the Plan, to enforce rights due under the Plan or any other causes of action that he or she may have against the Plan or its fiduciaries under applicable law, including ERISA.

PART II.
CONTINUATION COVERAGE

2.1 What are my continuation rights under COBRA?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires most employers to offer Employees and their families (spouse/domestic partner/common-law spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under an employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all the premium for the continuation coverage. The following Components shall be operated consistent with COBRA and pursuant to COBRA policies and procedures contained in a separate document, which is incorporated by reference into the Plan and this SPD and is available to you upon request, at no charge:

(a) Commercial Metals Company Medical Plan (Exhibit B);

(b) Commercial Metals Company California Medical Plan (Exhibit B-1);

(c) Commercial Metals Company Hawaii Health Plan (Exhibit C);

(d) Commercial Metals Company Dental Plan (Exhibit D);

(e) Commercial Metals Company Vision Plan (Exhibit E);

(f) Commercial Metals Company Healthcare Flexible Spending Account (Exhibit I);

(g) Commercial Metals Company Employee Assistance Plan (Exhibit K).

2.2 What are my continuation rights under USERRA?

If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible dependents under Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") for a period of up to 24 months. You and your eligible dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States. This continuation right is similar to, and runs concurrent with, your continuation rights under COBRA (if any). The following Components shall be operated consistent with USERRA and pursuant to USERRA policies and procedures contained in a separate document, which is incorporated by reference into the Plan and this SPD and is available to you upon request, at no charge:

(a) Commercial Metals Company Medical Plan (Exhibit B);

(b) Commercial Metals Company California Medical Plan (Exhibit B-1);

(c) Commercial Metals Company Hawaii Health Plan (Exhibit C);

(d) Commercial Metals Company Dental Plan (Exhibit D);

(e) Commercial Metals Company Vision Plan (Exhibit E);

(f) Commercial Metals Company Healthcare Flexible Spending Account (Exhibit I);

(g) Commercial Metals Company Employee Assistance Plan (Exhibit K).

2.3 What are my continuation and/or conversion rights for group health plan coverage under state law?

Some, but not all, states require continuation and/or conversion of group health insurance upon certain events. If provided under applicable state law, your continuation and/or conversion rights, and the rights of those who are covered through you, are described in the separate materials that have been provided to you either directly by the carrier (the insurance company) or by your Employer. If you have not been provided this information, you should contact the Employer.

2.4 What are my continuation and/or conversion rights for group term life insurance coverage under state law?

Some, but not all, states require continuation and/or conversion of group-term life insurance. The Commercial Metals Company Basic Life and AD&D Plan and Commercial Metals Company Voluntary Life and AD&D Plan (Exhibit F) ***may*** be subject to these state requirements. If provided under applicable state law, your continuation and/or conversion rights, and the rights of those who are covered through you, are described in the Coverage Contract.

PART III.
FAMILY AND MEDICAL LEAVE ACT OF 1993

3.1 Family and Medical Leave Act of 1993

The Family and Medical Leave Act of 1993 ("FMLA") requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for certain family and medical reasons. Employees are eligible if they have worked for their employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles. FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances.

Reasons for Taking Leave

Unpaid leave must be granted for any of the following reasons:

- To care for the employee's child after birth, or placement for adoption or foster care.
- To care for the employee's spouse/domestic partner/common-law spouse, son or daughter, or parent who has a serious health condition.
- For a serious health condition that makes the employee unable to perform the employee's job.
- At the employee's or employer's option, certain kinds of paid leave may be substituted for unpaid leave.

Military Family Leave Entitlements

Eligible employees with a spouse/domestic partner/common-law spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Advance Notice and Medical Certification

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days' advance notice when the leave is foreseeable.
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any group health plan.
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA.
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.
- FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For Additional Information

If you have access to the internet, visit the FMLA website at http://www.dol.gov/whd/fmla. To locate the nearest Wage-Hour Office, telephone the Wage-Hour toll-free information and help line at 1.866.4USWAGE (1.866.487.9243): a customer service representative is available to assist you with referral information from 8 a.m. to 5 p.m. in your time zone; or log onto http://www.wagehour.dol.gov.

PART IV.
STATEMENT OF ERISA RIGHTS

As a Participant in this Plan (including any Components), you are entitled to certain rights and protections under ERISA.

Receive Information About Your Plans and Benefits. ERISA provides that all Participants shall be entitled to:

(a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and 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.

(b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

(c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report ("SAR").

COBRA Rights. As a Participant in the Plan, you are entitled to continue health coverage for yourself, your spouse/domestic partner/common-law spouse or your dependents if there is a loss in coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the plan and do not receive them within thirty (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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the 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.

If it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have 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 if frivolous.

Very Important: Exhaustion of Administrative Procedures Required; Statute of Limitations. The right to maintain a court action is subject to the Plan's requirements that administrative procedures be completed first. This is called exhaustion of administrative remedies. ***Failure to exhaust administrative procedures may preclude you from bringing an action in court***. Furthermore, if you intend to initiate legal action related to the Plan, including legal action for benefits under the Plan pursuant to Section 502(a) of ERISA, you must do so within two (2) years after receipt of a notification of an adverse benefit determination at the final level of appeal provided under the Plan If, due to special circumstances, you were not required to exhaust your administrative remedies, legal action must be brought within two (2) years of the date the relevant claim for benefits was submitted to the Plan. You may not bring legal action after the expiration of the applicable limitations period. These deadlines for bring a legal action apply unless a different time period is provided in the Exhibit applicable to the Component with respect to which the action is being brought.

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

EXHIBIT A: Benefits Available Through the Welfare Benefit Plan for Employees of Commercial Metals Company

COMPONENT BENEFIT:	DESCRIPTION:	INSURER/PROVIDER/ CLAIMS ADMINSTRATOR INFORMATION AS OF JANUARY 1, 2023:
Commercial Metals Company Medical Plan [Exhibit B]	Some of the health (medical) coverage provided through the Plan is described in the component entitled Commercial Metals Company Medical Plan, which is described in Exhibit B.	BCBS of Texas 1001 East Lookout Drive Richardson, TX 75082 Group # 009123
Commercial Metals Company California Medical Plan [Exhibit B-1]	Some of the health (medical) coverage provided through the Plan is described in the component entitled Commercial Metals Company California Medical Plan, which is described in Exhibit B-1.	Kaiser Northern California Policy # 602827 KFHP California Claims Administration P.O. Box 12923 Oakland, CA 94604-2923 Kaiser Southern California Policy # 101708 Kaiser Permanente Claims Administration Department P.O. Box 7004 Downey, CA 90242-7004
Commercial Metals Company Hawaii Health Plan [Exhibit C]	Some of the medical, dental, and vision coverage provided through the Plan is described in the component entitled Commercial Metals Company Hawaii Health Plan, which is described in Exhibit E.	HMSA 16-541 Laukahi Place Kea'au Hawaii 96749 Policy # 29482
Commercial Metals Company Dental Plan [Exhibit D]	Some of the dental coverage provided through the Plan is described in the component entitled Commercial Metals Company Dental Plan, which is described in Exhibit D.	Delta Dental Insurance Company 1701 Shoal Creek, Suite 240 Highland, TX 75077 Group # 05838
Commercial Metals Company Vision Plan [Exhibit E]	Some of the vision coverage provided through the Plan is described in the component entitled Commercial Metals Company Vision Plan, which is described in Exhibit D.	Vision Service Plan Ins. Co. 3333 Quality Drive Rancho Cordova, CA 95670 Policy # 12247388
Commercial Metals Company Basic Life/AD&D Plan and Commercial Metals Company Voluntary Life/AD&D Plan [Exhibit F]	Group life and accidental death and dismemberment insurance coverage, including voluntary life and accidental death and dismemberment insurance coverage, provided through the Plan are described in the component entitled Commercial Metals Company Basic Life and AD&D Plan and Commercial Metals Company Voluntary Life and AD&D Plan, which is described in Exhibit F.	Lincoln Financial Group Mailing: PO Box 7206, London, KY 40742 Physical: 100 Liberty Way, Dover, NH 03820 Policy #: 09-466376
Commercial Metals Company Short Term Disability Plan [Exhibit G]	Short term disability insurance coverage provided through the Plan is described in the component entitled Commercial Metals Company Short Term Disability Plan, which is described in as Exhibit G.	Lincoln Financial Group Mailing: PO Box 7209, London, KY 40742 Physical: 2510 W Dunlap Ave, Suite 300, Phoenix, AZ 85021 Policy #: 09-466376
Commercial Metals Company Long Term Disability Plan [Exhibit H]	Long term disability coverage provided through the Plan is described in the component entitled Commercial Metals Company Long Term Disability Plan, which is described in Exhibit H.	Lincoln Financial Group Mailing: PO Box 7209, London, KY 40742 Physical: 2510 W Dunlap Ave, Suite 300, Phoenix, AZ 85021 Policy #: 09-466376

COMPONENT BENEFIT:	DESCRIPTION:	INSURER/PROVIDER/ CLAIMS ADMINSTRATOR INFORMATION AS OF JANUARY 1, 2023:
Commercial Metals Company Healthcare FSA [Exhibit I]	Reimbursement of medical expenses provided through the Plan is described in the component entitled Commercial Metals Company Healthcare Flexible Spending Account, which is described in Exhibit I.	HealthEquity, Reimbursement Accounts 15 W. Scenic Pointe Dr, Suite 100 Draper, UT 84020 Group # 24699
Commercial Metals Company Critical Illness, Accident & Hospital Indemnity Benefit Plan [Exhibit J]	Critical illness, hospital indemnity, and accident coverage provided through the Plan is described in the component entitled Commercial Metals Company Critical Illness, Accident & Hospital Indemnity Benefit Plan, which is described in Exhibit J.	Voya Financial 14643 Dallas Parkway, Suite 650 Addison, TX 75254 Policy # 70288-9
Commercial Metals Company Employee Assistance Plan [Exhibit K]	Employee assistance benefits provided through the Plan are described in the component entitled Commercial Metals Company Employee Assistance Plan, which is described in Exhibit K.	SupportLinc 314 West Superior Street Chicago, IL 60654 Group # cmc
Commercial Metals Company Business Travel Accident Plan [Exhibit L]	Business travel accident coverage provided through the Plan is described in the component entitled Commercial Metals Company Business Travel Accident Plan, which is described in Exhibit L.	STARR Assist 399 Park Avenue New York, NY 10022

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in the SPD shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Exhibit:	This Exhibit B that is attached to and made part of the SPD.
Component Plan:	Commercial Metals Company Medical Plan
Coverage Contract:	A separate document(s) incorporated herein by reference that describes in detail the coverage and benefits provided by this Component Plan. ***To request a copy of the Coverage Contract, which is available upon request at no cost, contact Employee Services via email at employeeservices@cmc.com or call 1.877.262.8050.***
Provider:	BCBS of Texas

Purpose

It is the intention of the Employer that this Component Plan qualifies as accident and health benefits under Sections 105 and 106 of the Code. It is also the intention of the Employer that this Component Plan be considered a "group health plan" as required under applicable law including, but not limited to, HIPAA, COBRA, ERISA, FMLA, and PPACA.

Terms and Conditions of Coverage

The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Component Plan Eligibility Requirements

Eligible Employees: You are eligible for coverage under this Component Plan if you are a full-time Employee working at least thirty (30) hours per week.

Waiting Period: The date on which your employment with the Employer begins.

Entry Date: If you are eligible, you will become covered under this Component Plan coinciding with your completion of the waiting period.

Funding Medium and Type of Plan Administration

This Component Plan is self-insured. The sole source of benefits under this portion of the Plan is the Employer's general assets. Benefits are not paid through insurance contracts and there is no trust. The Provider (not the Plan Administrator or Employer) is responsible for receiving and processing claims, although the Provider and the Plan Administrator share responsibility for administering the Component Plan.

The cost of your coverage (and that of your family) is paid in part by the Employer out of its general assets and in part by you through pre-tax payroll deductions. The Employer provides a schedule of the applicable Employee premiums.

Annual Open Enrollment

This Component Plan has annual open enrollment.

HIPAA Special Enrollment Rights

In certain cases, individuals are allowed to enroll in this Component Plan pursuant to HIPAA special enrollment at times other than open enrollment. Generally, special enrollment is available upon: (1) acquiring a new spouse/domestic partner/common-law spouse or dependent of spouse/domestic partner/common-law spouse, (2) losing other group coverage, (3) losing coverage under Medicaid or a state children's health insurance program ("SCHIP"), and (4) becoming eligible for a subsidy under Medicaid or SCHIP for coverage under Employer's group health plan. Please refer to the particular Coverage Contract for additional information regarding HIPAA special enrollment, including information regarding the situations in which special enrollment is available and the deadline for requesting special enrollment under the Component Plan.

Application of HIPAA Privacy and Security Rules

This Component Plan is considered a covered entity for purposes of the Privacy Rules and Security Rules. This Component Plan will comply with the Privacy Rules and Security Rules.

Plan Interpretation

To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

PPACA

The Plan Administrator uses the Utah benchmark plan to define what constitutes an essential health benefit under the Component Plan. This Component Plan constitutes minimal essential coverage in accordance with PPACA.

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in Article II of the Plan shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Exhibit:	This Exhibit B-1 that is attached hereto and made part of the Plan.
Component Plan:	Commercial Metals Company California Medical Plan
Coverage Contract	A separate document(s) incorporated herein by reference that describes in detail the coverage and benefits provided by this Component Plan. ***To request a copy of the Coverage Contract, which is available upon request at no cost, contact Employee Services via email at employeeservices@cmc.com or call 1.877.262.8050.***
Insurer:	Kaiser

Purpose

It is the intention of the Employer that this Component Plan qualifies as accident and health benefits under Sections 105 and 106 of the Code. It is also the intention of the Employer that this Component Plan be considered a "group health plan" as required under applicable law including, but not limited to, HIPAA, COBRA, ERISA, FMLA, and PPACA.

Terms and Conditions of Coverage

The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Component Plan Eligibility Requirements

Eligible Employees: You are eligible for coverage under this Component Plan if you are a full-time Employee who resides in California and works at least thirty (30) hours per week.

Waiting Period: The date on which your employment with the Employer begins.

Entry Date: If you are eligible, you will become covered under this Component Plan coinciding with your completion of the waiting period.

Funding Medium and Type of Plan Administration

This Component Plan is fully insured. Benefits are provided under the Coverage Contract entered into between the Employer and the Insurer. The Insurer (not the Employer or Plan Administrator) is responsible for processing claims or paying benefits, although both the Insurer and the Plan Administrator share responsibility for administering the Component Plan.

The cost of your coverage (and that of your family) is paid in part by the Employer out of its general assets and in part by your pre-tax payroll deductions. The Employer provides a schedule of the applicable Employee premiums.

Annual Open Enrollment

This Component Plan has annual open enrollment.

HIPAA Privacy and Security Rules

This Component Plan is considered a covered entity for purposes of the Privacy Rules and Security Rules. This Component Plan will comply with the Privacy Rules and Security Rules.

HIPAA Special Enrollment Rights	In certain cases, individuals are allowed to enroll in this Component Plan pursuant to HIPAA special enrollment at times other than open enrollment. Generally, special enrollment is available upon: (1) acquiring a new spouse/domestic partner/common-law spouse or dependent of spouse/domestic partner/common-law spouse, (2) losing other group coverage, (3) losing coverage under Medicaid or a state children's health insurance program ("SCHIP"), and (4) becoming eligible for a subsidy under Medicaid or SCHIP for coverage under the Employer's group health plan. Please refer to the particular Coverage Contract for additional information regarding HIPAA special enrollment, including information regarding the situations in which special enrollment is available and the deadline for requesting special enrollment under the Component Plan.
Plan Interpretation	To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).
PPACA	The Plan Administrator uses the Utah benchmark plan to define what constitutes an essential health benefit under the Component Plan. This Component Plan constitutes minimal essential coverage in accordance with PPACA.

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in the SPD shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Exhibit:	This Exhibit C that is attached to and made part of the SPD.
Component Plan:	Commercial Metals Company Hawaii Health Plan
Coverage Contract:	A separate document(s) incorporated herein by reference that describes in detail the coverage and benefits provided by this Component Plan. ***To request a copy of the Coverage Contract, which is available upon request at no cost, contact Employee Services via email at employeeservices@cmc.com or call 1.877.262.8050.***
Insurer:	HMSA

Purpose

It is the intention of the Employer that this Component Plan qualifies as accident and health benefits under Sections 105 and 106 of the Code. It is also the intention of the Employer that this Component Plan be considered a "group health plan" as required under applicable law including, but not limited to, HIPAA, COBRA, ERISA, FMLA, and PPACA.

Terms and Conditions of Coverage

The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Component Plan Eligibility Requirements

Eligible Employees: You are eligible for coverage under this Component Plan if you are an Employee who works in Hawaii and is scheduled to work twenty (20) or more hours per week for four (4) consecutive weeks.

Waiting Period: First of the month following four (4) consecutive weeks beginning on the date on which your employment with the Employer begins.

Entry Date: If you are eligible, you will become covered under this Component Plan on the later of (1) the first day of the month following your completion of the waiting period, or (2) the first day of the month coinciding with or following the date on which you become an Eligible Employee.

Funding Medium and Type of Plan Administration

This Component Plan is fully insured. Benefits are provided under the Coverage Contract entered into between the Employer and the Insurer. The Insurer (not the Employer or Plan Administrator) is responsible for processing claims or paying benefits, although both the Insurer and the Plan Administrator share responsibility for administering the Component Plan.

The cost of your coverage (and that of your family) is paid in part by the Employer out of its general assets and in part by your pre-tax payroll deductions. The Employer provides a schedule of the applicable Employee premiums.

Annual Open Enrollment

This Component Plan has annual open enrollment.

HIPAA Privacy and Security Rules

This Component Plan is considered a covered entity for purposes of the Privacy Rules and Security Rules. This Component Plan will comply with the Privacy Rules and Security Rules.

HIPAA Special Enrollment Rights

In certain cases, individuals are allowed to enroll in this Component Plan pursuant to HIPAA special enrollment at times other than open enrollment. Generally, special enrollment is available upon: (1) acquiring a new spouse/domestic partner/common-law spouse or dependent of spouse/domestic partner/common-law spouse, (2) losing other group coverage, (3) losing coverage under Medicaid or a state children's health insurance program ("SCHIP"), and (4) becoming eligible for a subsidy under Medicaid or SCHIP for coverage under the Employer's group health plan. Please refer to the particular Coverage Contract for additional information regarding HIPAA special enrollment, including information regarding the situations in which special enrollment is available and the deadline for requesting special enrollment under the Component Plan.

Plan Interpretation

To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

PPACA

This Component Plan constitutes minimal essential coverage in accordance with PPACA.

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in the SPD shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Exhibit:	This Exhibit D that is attached to and made part of the SPD.
Component Plan:	Commercial Metals Company Dental Plan
Coverage Contract:	A separate document(s) incorporated herein by reference that describes in detail the coverage and benefits provided by this Component Plan. ***To request a copy of the Coverage Contract, which is available upon request at no cost, contact Employee Services via email at employeeservices@cmc.com or call 1.877.262.8050.***
Provider:	Delta Dental Insurance Company

Purpose

It is the intention of the Employer that this Component Plan qualifies as accident and health benefits under Sections 105 and 106 of the Code. It is also the intention of the Employer that this Component Plan be considered a "group health plan" as required under applicable law including, but not limited to, HIPAA, COBRA, ERISA, and FMLA. Notwithstanding the foregoing, this Component Plan is intended to be an excepted benefit for purposes of HIPAA and, as a result, is exempt from the portability provisions of HIPAA and from PPACA.

Terms and Conditions of Coverage

The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Component Plan Eligibility Requirements

Eligible Employees: You are eligible for coverage under this Component Plan if you are a full-time Employee working at least thirty (30) hours per week.

Waiting Period: The date on which your employment with the Employer begins.

Entry Date: If you are eligible, you will become covered under this Component Plan coinciding with your completion of the waiting period.

Funding Medium and Type of Plan Administration

This Component Plan is self-insured. The sole source of benefits under this portion of the Plan is the Employer's general assets. Benefits are not paid through insurance contracts and there is no trust. The Provider (not the Plan Administrator or Employer) is responsible for receiving and processing claims, although both the Provider and the Plan Administrator share responsibility for administering the Component Plan.

The cost of your coverage (and that of your family) is 100% paid by the employee. The Employer provides a schedule of the applicable Employee premiums.

Annual Open Enrollment

This Component Plan has annual open enrollment.

HIPAA Privacy and Security Rules

This Component Plan is considered a covered entity for purposes of the Privacy Rules and Security Rules. This Component Plan will comply with the Privacy Rules and Security Rules.

Plan Interpretation	To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in the SPD shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Exhibit:	This Exhibit E that is attached to and made part of the SPD.
Component Plan:	Commercial Metals Company Vision Plan
Coverage Contract:	A separate document(s) incorporated herein by reference that describes in detail the coverage and benefits provided by this Component Plan. ***To request a copy of the Coverage Contract, which is available upon request at no cost, contact Employee Services via email at employeeservices@cmc.com or call 1.877.262.8050.***
Insurer:	Vision Service Plan Ins. Co.

Purpose

It is the intention of the Employer that this Component Plan qualifies as accident and health benefits under Sections 105 and 106 of the Code. It is also the intention of the Employer that this Component Plan be considered a "group health plan" as required under applicable law including, but not limited to, HIPAA, COBRA, ERISA, and FMLA. Notwithstanding the foregoing, this Component Plan is intended to be an excepted benefit for purposes of HIPAA and, as a result, is exempt from the portability provisions of HIPAA and from PPACA.

Terms and Conditions of Coverage

The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Component Plan Eligibility Requirements

Eligible Employees: You are eligible for coverage under this Component Plan if you are a full-time Employee working at least thirty (30) hours per week.

Waiting Period: The date on which your employment with the Employer begins.

Entry Date: If you are eligible, you will become covered under this Component Plan coinciding with your completion of the waiting period.

Funding Medium and Type of Plan Administration

This Component Plan is fully insured. Benefits are provided under the Coverage Contract entered into between the Employer and the Insurer. The Insurer (not the Employer or Plan Administrator) is responsible for processing claims or paying benefits, although both the Insurer and the Plan Administrator share responsibility for administering the Component Plan.

The cost of your coverage (and that of your family) is paid 100% by the employee. The Employer provides a schedule of applicable Employee premiums.

Annual Open Enrollment

This Component Plan has annual open enrollment.

HIPAA Privacy and Security Rules	This Component Plan is considered a covered entity for purposes of the Privacy Rules and Security Rules. This Component Plan will comply with the Privacy Rules and Security Rules.
Plan Interpretation	To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (Including this Component Plan).

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in the SPD shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Exhibit:	This Exhibit F that is attached to and made part of the SPD.
Component Plan:	Commercial Metals Company Basic Life and AD&D Plan and Commercial Metals Company Voluntary Life and AD&D Plan
Coverage Contract:	A separate document(s) incorporated herein by reference that describes in detail the coverage and benefits provided by this Component Plan. ***To request a copy of the Coverage Contract, which is available upon request at no cost, contact Employee Services via email at employeeservices@cmc.com or call 1.877.262.8050.***
Insurer:	Lincoln Financial Group

Purpose

It is the intention of the Employer that this Component Plan qualifies as group term life insurance under Section 79 of the Code and accident benefits under Section 105 and 106 of the Code. It is also the intention of the Employer that this Component Plan not be considered a "group health plan" for any purposes including, but not limited to, HIPAA, COBRA, ERISA, and FMLA.

Terms and Conditions of Coverage

The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Component Plan Eligibility Requirements

Eligible Employees: You are eligible for coverage under this Component Plan if:

- You are a full-time Employee working at least thirty (30) hours per week. (Class I), or
- You are an employee working in in Hawaii who is scheduled to work twenty (20) or more hours per week for four (4) consecutive weeks (Class II).

Waiting Period:

- Class I: The date on which your employment with the Employer begins.
- Class II: First of the month following four (4) consecutive weeks beginning on the date on which your employment with the Employer begins.

Entry Date: If you are eligible, you will become covered under this Component Plan:

- Class I: If you are eligible, you will become covered under this Component Plan coinciding with your completion of the waiting period.
- Class II: On the later of (1) the first day of the month following the date on which you complete the waiting period or (2) the first day of the month coinciding with or following the date on which you become an Eligible Employee.

Funding Medium and Type of Plan Administration	This Component Plan is fully insured. Benefits are provided under the Coverage Contract entered into between the Employer and the Insurer. The Insurer (not the Employer or Plan Administrator) is responsible for processing claims and paying benefits, although both the Insurer and the Plan Administrator share responsibility for administering the Component Plan. **Basic Coverage**: The cost of coverage is paid by the Employer out of its general assets. **Voluntary Coverage**: The cost of coverage is paid by your after-tax payroll deductions. The Employer provides a schedule of the applicable premiums.
Annual Open Enrollment	This Component Plan has annual open enrollment for voluntary coverage only to the extent allowed by the Insurer. There is no open enrollment for basic coverage.
Plan Interpretation	To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in the SPD shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Exhibit:	This Exhibit G that is attached to and made part of the SPD.
Component Plan:	Commercial Metals Company Short Term Disability Plan
Coverage Contract:	A separate document(s) incorporated herein by reference that describes in detail the coverage and benefits provided by this Component Plan. ***To request a copy of the Coverage Contract, which is available upon request at no cost, contact Employee Services via email at employeeservices@cmc.com or call 1.877.262.8050.***
Insurer:	Lincoln Financial Group

Purpose

It is the intention of the Employer that this Component Plan qualifies as accident benefits under Sections 104, 105 and 106 of the Code. It is also the intention of the Employer that this Component Plan not be considered a "group health plan" for any purposes including, but not limited to, HIPAA, COBRA, ERISA, and FMLA.

Terms and Conditions of Coverage

The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Component Plan Eligibility Requirements

Eligible Employees: You are eligible for coverage under this Component Plan if:

- You are a full-time Employee working at least thirty (30) hours per week . (Class I), or
- You are an employee working in in Hawaii who is scheduled to work twenty (20) or more hours per week for four (4) consecutive weeks (Class II).

Waiting Period:

- Class I: The date on which your employment with the Employer begins.
- Class II: First of the month following four (4) consecutive weeks beginning on the date on which your employment with the Employer begins.

Entry Date: If you are eligible, you will become covered under this Component Plan:

- Class I: If you are eligible, you will become covered under this Component Plan coinciding with your completion of the waiting period.
- Class II: On the later of (1) the first day of the month following the date on which you complete the waiting period or (2) the first day of the month coinciding with or following the date on which you become an Eligible Employee.

Funding Medium and Type of Plan Administration	This Component Plan is self-insured. Benefits are provided under the Coverage Contract entered into between the Employer and the Insurer. The Insurer (not the Employer or Plan Administrator) is responsible for processing claims and paying benefits, although both the Insurer and the Plan Administrator share responsibility for administering the Component Plan. The cost of coverage is paid by the Employer out of its general assets.
Annual Open Enrollment	This Component Plan does not have annual open enrollment.
Plan Interpretation	To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in the SPD.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Exhibit:	This Exhibit H that is attached to and made part of the SPD.
Component Plan:	Commercial Metals Company Long Term Disability Plan
Coverage Contract:	A separate document(s) incorporated herein by reference that describes in detail the coverage and benefits provided by this Component Plan. ***To request a copy of the Coverage Contract, which is available upon request at no cost, contact Employee Services via email at employeeservices@cmc.com or call 1.877.262.8050.***
Insurer:	Lincoln Financial Group

Purpose

It is the intention of the Employer that this Component Plan qualifies as accident benefits under Sections 104, 105 and 106 of the Code. It is also the intention of the Employer that this Component Plan not be considered a "group health plan" for any purposes including, but not limited to, HIPAA, COBRA, ERISA, and FMLA.

Terms and Conditions of Coverage

The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Component Plan Eligibility Requirements

Eligible Employees: You are eligible for coverage under this Component Plan if:

- You are a full-time Employee working at least thirty (30) hours per week . (Class I), or
- You are an employee working in in Hawaii who is scheduled to work twenty (20) or more hours per week for four (4) consecutive weeks (Class II).

Waiting Period:

- Class I: The date on which your employment with the Employer begins.
- Class II: First of the month following four (4) consecutive weeks beginning on the date on which your employment with the Employer begins.

Entry Date: If you are eligible, you will become covered under this Component Plan:

- Class I: If you are eligible, you will become covered under this Component Plan coinciding with your completion of the waiting period.
- Class II: On the later of (1) the first day of the month following the date on which you complete the waiting period or (2) the first day of the month coinciding with or following the date on which you become an Eligible Employee.

Funding Medium and Type of Plan Administration

This Component Plan is fully insured. The sole source of benefits under this portion of the Plan is the Employer's general assets. Benefits are not paid through insurance contracts and there is no trust. The Provider (not the Plan Administrator or Employer) is responsible for receiving and processing claims, although both the Provider and the Plan Administrator share responsibility for administering the Component Plan. The cost of coverage is paid by the Employer out of its general assets.

Annual Open Enrollment	This Component Plan does not have annual open enrollment.
Plan Interpretation	To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in the SPD shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Exhibit:	This Exhibit I that is attached to and made part of the SPD.
Component Plans:	Commercial Metals Company Healthcare Flexible Spending Account
Coverage Contract:	A separate document(s) incorporated herein by reference that describes in detail the coverage and benefits provided by these Component Plans. These Component Plans are part of the Employer's cafeteria plan. As a result, the Coverage Contract may include information regarding benefits other than these Component Plans. Of the benefits described in the Coverage Contract, only those that are specifically described in this SPD are part of this Plan. ***To request a copy of the Coverage Contract, which is available upon request at no cost, contact Employee Services via email at employeeservices@cmc.com or call 1.877.262.8050.***
Provider:	HealthEquity

Purpose

It is the intention of the Employer that these Component Plans qualify as accident and health benefits under Sections 105 and 106 of the Code. It is also the intention of the Employer that these Component Plans be considered a "group health plan" as required under applicable law including, but not limited to, HIPAA, COBRA, ERISA, and FMLA. Notwithstanding the foregoing, these Component Plans are intended to be an excepted benefit for purposes of HIPAA and, as a result, is exempt from the portability provisions of HIPAA and from PPACA.

Terms and Conditions of Coverage

The terms and conditions of coverage including, but not limited to, benefits provided, eligibility requirements, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Component Plan Eligibility Requirements

Eligible Employees: You are eligible for coverage under this Component Plan if:

- You are a full-time Employee working at least thirty (30) hours per week . (Class I), or
- You are an employee working in in Hawaii who is scheduled to work twenty (20) or more hours per week for four (4) consecutive weeks (Class II).

Waiting Period:

- Class I: The date on which your employment with the Employer begins.
- Class II: First of the month following four (4) consecutive weeks beginning on the date on which your employment with the Employer begins.

Entry Date: If you are eligible, you will become covered under this Component Plan:

- Class I: If you are eligible, you will become covered under this Component Plan coinciding with your completion of the waiting period.
- Class II: On the later of (1) the first day of the month following the date on which you complete the waiting period or (2) the first day of the month coinciding with or following the date on which you become an Eligible Employee.

Funding Medium and Type of Plan Administration	These Component Plans are self-insured. The sole source of benefits under this portion of the Plan is the Employer's general assets. Benefits are not paid through insurance contracts and there is no trust. The Provider (not the Plan Administrator or Employer) is responsible for receiving and processing claims, although the Provider and the Plan Administrator share responsibility for administering the Component Plan. Funding for these Component Plan is provided through your pre-tax payroll deductions or after-tax payments (e.g., if you have insufficient compensation for payroll deductions or you elect to make after-tax payments).
Annual Open Enrollment	These Component Plans have annual open enrollment.
HIPAA Privacy and Security Rules	These Component Plans are considered a covered entity for purposes of the Privacy Rules and Security Rules. These Component Plans will comply with the Privacy Rules and Security Rules.
Plan Interpretation	To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including these Component Plans) shall have the authority and discretion to interpret and apply Plan (including these Component Plans) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including these Component Plans).

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in the SPD shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Exhibit:	This Exhibit J that is attached to and made part of the SPD.
Component Plan:	Commercial Metals Company Critical Illness, Accident & Hospital Indemnity Benefit Plan
Coverage Contract:	A separate document(s) incorporated herein by reference that describes in detail the coverage and benefits provided by this Component Plan. ***To request a copy of the Coverage Contract, which is available upon request at no cost, contact Employee Services via email at employeeservices@cmc.com or call 1.877.262.8050.***
Insurer:	Voya Financial

Purpose

It is the intention of the Employer that the provision of benefits through this portion of the Plan qualifies as accident and health benefits under Section 104 of the Code. It is also the intention of the Employer that this portion of the Plan not be considered a "group health plan" for any purposes including, but not limited to, HIPAA, COBRA, ERISA, and FMLA. Notwithstanding the foregoing, this portion of the Plan is intended to be an excepted benefit for purposes of HIPAA and, as a result, is exempt from the portability provisions of HIPAA and from PPACA.

Terms and Conditions of Coverage

The terms and conditions of coverage including, but not limited to, benefits provided, eligibility requirements, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Component Plan Eligibility Requirements

Eligible Employees: You are eligible for coverage under this Component Plan if:

- You are a full-time Employee working at least thirty (30) hours per week. (Class I), or
- You are an employee working in in Hawaii who is scheduled to work twenty (20) or more hours per week for four (4) consecutive weeks (Class II).

Waiting Period:

- Class I: The date on which your employment with the Employer begins.
- Class II: First of the month following four (4) consecutive weeks beginning on the date on which your employment with the Employer begins.

Entry Date: If you are eligible, you will become covered under this Component Plan:

- Class I: If you are eligible, you will become covered under this Component Plan coinciding with your completion of the waiting period.
- Class II: On the later of (1) the first day of the month following the date on which you complete the waiting period or (2) the first day of the month coinciding with or following the date on which you become an Eligible Employee.

Funding Medium and Type of Plan Administration

This Component Plan is fully insured. Benefits are provided under the Coverage Contract entered into between the Employer and the Insurer. The Insurer (not the Employer or Plan Administrator) is responsible for processing claims or paying benefits, although both the Insurer and the Plan Administrator share responsibility for administering the Component Plan. The cost of your coverage (and that of your family) is paid by your after-tax payroll deductions. The Employer provides a schedule of the applicable Employee premiums.

Annual Open Enrollment

This Component Plan has annual open enrollment.

HIPAA Privacy and Security Rules

To the extent it is considered a covered entity for purposes of the Privacy Rules and Security Rules, this Component Plan will comply with the Privacy Rules and Security Rules as further provided in the Coverage Contract.

Plan Interpretation

To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in the SPD shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Exhibit:	This Exhibit K that is attached to and made part of the SPD.
Component Plan:	Commercial Metals Company Employee Assistance Plan
Coverage Contract:	A separate document(s) incorporated herein by reference that describes in detail the coverage and benefits provided by this Component Plan. ***To request a copy of the Coverage Contract, which is available upon request at no cost, contact Employee Services via email at employeeservices@cmc.com or call 1.877.262.8050.***
Provider:	Curalinc

Purpose

It is the intention of the Employer that this Component Plan qualifies as accident and health benefits under Sections 105 and 106 of the Code. It is also the intention of the Employer that this Component Plan be considered a "group health plan" as required under applicable law including, but not limited to, HIPAA, COBRA, ERISA, FMLA, and PPACA. Notwithstanding the foregoing, this portion of the Plan is intended to be an excepted benefit for purposes of HIPAA and, as a result, is exempt from the portability provisions of HIPAA and from PPACA.

Terms and Conditions of Coverage

The terms and conditions of coverage including, but not limited to, benefits provided, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Component Plan Eligibility Requirements

Eligible Employees: You are eligible for coverage under this Component Plan if:

- You are a full-time Employee working at least thirty (30) hours per week. (Class I), or
- You are an employee working in in Hawaii who is scheduled to work twenty (20) or more hours per week for four (4) consecutive weeks (Class II).

Waiting Period:

- Class I: The date on which your employment with the Employer begins.
- Class II: First of the month following four (4) consecutive weeks beginning on the date on which your employment with the Employer begins.

Entry Date: If you are eligible, you will become covered under this Component Plan:

- Class I: If you are eligible, you will become covered under this Component Plan coinciding with your completion of the waiting period.
- Class II: On the later of (1) the first day of the month following the date on which you complete the waiting period or (2) the first day of the month coinciding with or following the date on which you become an Eligible Employee.

Funding Medium and Type of Plan Administration

This Component Plan is fully insured. The sole source of benefits under this portion of the Plan is the Employer's general assets. Benefits are not paid through insurance contracts and there is no trust. The Provider (not the Plan Administrator or Employer) is responsible for providing benefits, although both the Provider and the Plan Administrator share responsibility for administering the Component Plan. The cost of coverage is paid by the Employer out of its general assets.

Annual Open Enrollment	This Component Plan does not have annual open enrollment.
Application of HIPAA Privacy and Security Rules	This Component Plan is considered a covered entity for purposes of the Privacy Rules and Security Rules. This Component Plan will comply with the Privacy Rules and Security Rules.
Plan Interpretation	To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

Component Plan Definitions: Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in the SPD shall apply.

Eligible Employee:	Any Employee that satisfies the Component Plan's eligibility requirements as set forth herein.
Exhibit:	This Exhibit L that is attached to and made part of the SPD.
Component Plan:	Commercial Metals Company Business Travel Accident Plan
Coverage Contract:	A separate document(s) incorporated herein by reference that describes in detail the coverage and benefits provided by this Component Plan. ***To request a copy of the Coverage Contract, which is available upon request at no cost, contact Employee Services via email at employeeservices@cmc.com or call 1.877.262.8050.***
Insurer:	STARR Assist

Purpose

It is the intention of the Employer that this Component Plan qualifies as accident and health benefits under Sections 104, 105 and 106 of the Code. It is also the intention of the Employer that this portion of the Plan not be considered a "group health plan" for any purposes including, but not limited to, HIPAA, COBRA, ERISA, and FMLA. Notwithstanding the foregoing, this portion of the Plan is intended to be an excepted benefit for purposes of HIPAA and, as a result, is exempt from the portability provisions of HIPAA and from PPACA.

Terms and Conditions of Coverage

The terms and conditions of coverage including, but not limited to, benefits provided, eligibility requirements, requirements for participation, procedures for submitting claims, procedures for appealing claims denials, etc., are reflected in the Coverage Contract.

Component Plan Eligibility Requirements

Eligible Employees and Dependents: You (and your dependents) are eligible for this Component Plan if you are in any of the following classes:

- Class I: All active U.S. Employees excluding truck drivers while performing their regular driving assignments.
- Class II: Spouses/Domestic Partners/Common-Law Spouses of Participants while they are accompanying the Participant on a business or relocation trip.
- Class III: Dependent children of Participants while they are accompanying the Participant on a business or relocation trip.
- Class IV: All full-time non-U.S. officers, department heads, managers, and supervisors.

Waiting Period: The date on which your employment with the Employer begins or, if employed in Hawaii, first of the month following four (4) consecutive weeks beginning on the date on which your employment with the Employer begins.

Entry Date: Your participation in the Component Plan may begin on the day coinciding with your completion of the waiting period. Notwithstanding the foregoing, if you work in Hawaii, your participation may begin on the later of (1) the first day of the month following the date on which you complete the waiting period or (2) the first day of the month coinciding with or following the date on which you become an Eligible Employee.

Funding Medium and Type of Plan Administration

This Component Plan is fully insured. Benefits are provided under the Coverage Contract entered into between the Employer and the Insurer. The Insurer (not the Employer or Plan Administrator) is responsible for processing claims and paying benefits, although both the Insurer and the Plan Administrator share responsibility for administering the Component Plan. The cost of coverage is paid by the Employer out of its general assets.

Annual Open Enrollment	This Component Plan does not have annual open enrollment.
Plan Interpretation	To the fullest extent permitted under applicable law, the fiduciaries of the Plan (including this Component Plan) shall have the authority and discretion to interpret and apply Plan (including this Component Plan) terms. For purposes of this provision, "fiduciaries" includes any insurance carrier, third party administrator, or other third party that makes claims determinations for benefits under the Plan (including this Component Plan).

Article I. General Provisions

1.1 **Purpose.** To the extent a Coverage Contract does not contain a claims and claims appeal procedure compliant with ERISA, this Exhibit M shall apply with respect to the Component.

1.2 **Claim Submission.** A claim for benefits must be made in writing and submitted to the Plan in accordance with the procedures described in the applicable Coverage Contract.

> **Note:** Claims and appeals for benefits provided through an insurance contract are handled directly by the insurance company.

1.3 **Definitions.** The following definitions shall apply for purposes of Exhibit M only:

(a) **Adverse Benefit Determination** means a denial, reduction, or termination of a Benefit, a failure to provide or make payment (in whole or in part) for a Benefit, or a Rescission.

(b) **Authorized Representative** means a person designated by a Claimant or the Plan to act on behalf of a Claimant with respect to a Benefit claim or appeal. An assignment for purposes of payment is ***not*** designation of an "Authorized Representative."

(c) **Claimant** means a person who believes he/she is entitled to benefits under the Plan. The term Claimant shall also include a Claimant's Authorized Representative, if applicable.

(d) **Concurrent Care Claim** means a claim with prior authorization that is reconsidered after a course of treatment has been initially approved. There are two types of Concurrent Care Claims: (i) where the reconsideration results in a reduction or termination of coverage for a previously approved course of treatment, and (ii) where an extension is requested by the Claimant for coverage beyond the initially approved course of treatment.

(e) **External Review** means, to the extent required by and in accordance with PPACA, an independent review of an Adverse Benefit Determination (following final appeal under the Plan) under applicable state or federal external review procedures.

(f) **Post-Service Claim** means any claim for a Benefit under the Plan that is submitted for payment or reimbursement after the services have been rendered.

(g) **Pre-Service Claim** means any claim for a Benefit under the Plan where receipt of the Benefit is specifically conditioned, in whole or in part, on receiving approval in advance of obtaining the medical care.

(h) **Urgent Pre-Service Claim** means a specific type of Pre-Service Claim under the Plan. An Urgent Pre-Service Claim is any claim for medical care or treatment with respect to which the application of the timeframes for making non-urgent determinations: (i) could seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or (ii) in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If a physician with knowledge of the Claimant's medical condition determines that a claim is an Urgent Pre-Service Claim, the claim will be treated as an Urgent Pre-Service Claim. A physician may be required to complete an "Urgent Pre-Service Claim Determination by Physician" form, if requested, in such cases.

1.4 **Types of Claims.**

(a) There are four categories of claims as defined above:

(1) Concurrent Care Claim;

(2) Post-Service Claim;

(3) Pre-Service Claim; and

(4) Urgent Pre-Service Claim.

(b) Each category of claim has its own set of claim and appeal requirements. The primary difference between the categories of claims is the timeframe within which claims will be determined.

(c) For the purpose of determining which claim and appeal procedures to follow, the claim type is determined initially. However, if the nature of the claim changes as it proceeds through the claim and appeal process, the claim can be re-characterized. For example, a claim may initially be an Urgent Pre-Service Claim. If the urgency subsides, it may be re-characterized as a Pre-Service Claim. Once the services are rendered and submitted to the Plan for payment, it becomes a Post-Service Claim.

1.5 **Authorized Representative.** For purposes of the claims and appeal procedures an Authorized Representative may act on a Claimant's behalf with respect to any aspect of a claim or appeal.

For Pre-Service Claims, Urgent Pre-Service Claims, and Concurrent Care Claims, the Plan will recognize a healthcare provider with knowledge of the Claimant's medical condition (e.g., the treating physician) as the Claimant's Authorized Representative for both claims and appeals, unless the Claimant provides specific written direction otherwise.

For Post-Service Claims and Claims under Articles IX and X, in order for the Plan to recognize a person as an Authorized Representative, written notification to that effect, signed by the Claimant and notarized, must be received by the Plan Administrator.

Once an Authorized Representative is recognized, the Plan will direct all information, notification, etc. regarding the claim to the Authorized Representative, unless the Claimant provides specific written direction otherwise.

1.6 **Access to Relevant Documents.** In order (1) to evaluate whether to request review of an Adverse Benefit Determination, and (2) if review is requested, to prepare for such review, the Claimant or the Claimant's Authorized Representative 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. A document, record or other information is "relevant" if it was relied upon in making the determination, or was submitted to the Plan, considered by the Plan, or generated in the course of making the Benefit determination without regard to whether it was relied upon in making the Benefit determination.

1.7 **Questions Regarding Claims and Appeals Procedures.** If a Claimant has any questions regarding these procedures, the Claimant should contact the Plan Administrator.

1.8 **Conflicts of Interest.** All claims and appeals will be adjudicated in a manner so that the independence and impartiality of the persons involved in making the determination are ensured. Decisions regarding hiring, compensation, termination, and similar matters with respect to any person involved in the determination (e.g., a claims adjudicator or medical expert) shall not be based upon the likelihood that the person will support a denial of benefits.

1.9 **Legal Action.** If a Claimant intends to initiate legal action, including legal action under Section 502(a) of ERISA, he or she must do so within two (2) years after receipt of a notification of an Adverse Benefit Determination at the final level of appeal, unless a different time period is provided in the Coverage Contract applicable to the Benefit with respect to which the action is being brought. If, due to special circumstances, the Claimant was not required to complete the appeals process outlined below, legal action

must be brought within two (2) years of the date the Claimant's claim for benefits was submitted to this Plan, unless a different time period is provided in the Coverage Contract applicable to the Benefit with respect to which the action is being brought. Claimants may not bring legal action after the expiration of the applicable limitations period. With respect to benefits subject to PPACA, this provision applies to the fullest extent consistent with applicable PPACA requirements.

ARTICLE II.CLAIMS AND APPEAL PROCEDURES FOR GROUP HEALTH PLANS

2.1 **Purpose.** This Article II shall generally apply with respect to Components that constitutes a group health plan for purposes of 29 C.F.R. § 2560.503-1, to the extent a Coverage Contract governing such Component does not contain a claims and claims appeal procedure compliant with ERISA including, if applicable, PPACA. However, if a claim for benefits constitutes a claim for disability benefits, such claim shall be subject to Article III.

2.2 **Timeframes for Claim Decisions.** A Claimant may voluntarily agree to extend the timeframes specified below for the Plan to make a decision.

(a) **Timeframes.** The following timeframes apply unless the claim is incomplete, as described below.

(1) **Post-Service Claims.** The Plan will determine the claim within a reasonable period of time not to exceed thirty (30) days from receipt of the claim.

If the Plan is not able to determine the claim within this time period due to matters beyond its control, the Plan may take an additional period of up to fifteen (15) days to determine the claim. If this additional time will be needed, the Plan will notify the Claimant in writing prior to the expiration of the initial thirty (30) day time period for determining the claim.

(2) **Pre-Service Claims.** The Plan will determine the claim within a reasonable period of time not to exceed fifteen (15) days from receipt of the claim.

If the Plan is not able to determine the claim within this time period due to matters beyond its control, the Plan may take an additional period of up to fifteen (15) days to determine the claim. If this additional time will be needed, the Plan will notify the Claimant in writing prior to the expiration of the initial fifteen (15) day time period for determining the claim.

(3) **Urgent Pre-Service Claims.** The Plan will determine the claim as soon as possible taking into account medical exigencies, but no later than seventy-two (72) hours after receipt of the claim by the Plan.

(4) **Concurrent Care Claims.**

(i) For a reduction or termination of coverage for a previously approved ongoing course of treatment, the Plan will make the determination sufficiently in advance to allow the Claimant to appeal and obtain a determination on review before coverage for the previously approved course of treatment is reduced or terminated.

(ii) Where an extension is requested by the Claimant for coverage beyond the initially approved course of treatment, and

a. If the request meets the definition of an Urgent Pre-Service Claim and is filed at least twenty-four (24) hours prior to the end of the course of treatment, the Plan will determine the claim as soon as possible, but no later twenty-four (24) hours after receipt of the request.

b. If the request meets the definition of an Urgent Pre-Service Claim and is filed less than twenty-four (24) hours prior to the end of the course of treatment, the Plan will determine the claim as soon as possible, but no later than seventy-two (72) hours after receipt of the request.

c. If the request does not meet the definition of an Urgent Pre-Service Claim, the Plan will determine the claim within a reasonable period of time not to exceed fifteen (15) days from receipt of the request. If the Plan is not able to determine the claim within this time period due to matters beyond its control, the Plan may take an additional period of up to fifteen (15) days to determine the claim. If this additional time will be needed, the Plan will notify the Claimant in writing prior to the expiration of the initial time period for determining the claim.

(b) **Incorrectly Filed and Incomplete Claims**.

(1) **Incorrectly Filed Pre-Service Claims and Urgent Pre-Service Claims.** If there is a communication by a Claimant that (i) is received by a person or organizational unit customarily responsible for handling benefit matters for the Employer, (ii) names a specific Claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested, and (iii) fails to follow the Plan's procedures for filing a Pre-Service Claim or an Urgent Pre-Service Claim, the Plan will notify the Claimant and explain the proper procedures as soon as possible, but no later than five (5) days from receipt of the communication regarding a Pre-Service Claim and no later than twenty-four (24) hours from receipt of the communication regarding an Urgent Pre-Service Claim. Notification may be made orally to the Claimant unless the Claimant requests written notice.

(2) **Incomplete Post-Service Claims and Pre-Service Claims (not including Urgent Pre-Service Claims).** Incomplete claims can be addressed through the extension of time described above. If the reason for the extension is the failure to provide necessary information and the Claimant is appropriately notified, the Plan's period of time to make a decision is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the Claimant responds or should have responded.

The notification will include a timeframe of at least forty-five (45) days in which the necessary information must be provided. Once the necessary information has been provided, the Plan will decide the claim within the extension described above. If the requested information is not provided within the time specified, the claim may be denied.

(3) **Incomplete Urgent Pre-Service Claims.** The Plan will notify the Claimant of an incomplete claim as soon as possible, but no later than twenty-four (24) hours following receipt of the incomplete claim. The notification will describe the information necessary to complete the claim and specify the timeframe of at least forty-eight (48) hours within which the claim must be complete. Notification may be made orally to the Claimant unless the Claimant requests written notice.

The Plan will make a claim determination as soon as possible but not later than the earlier of (i) forty-eight (48) hours after receipt of the specified information, or (ii) the end of the period of time provided to submit the specified information.

2.3 **Notification of Claim Decisions.**

(a) **Timeframe and Notification of a Claim Determination**.

(1) Notification will be provided within the time frames contained in Section 2.2(a) only if the decision is an Adverse Benefit Determination for Post-Service Claims and Concurrent Care Claims.

(2) Notification will be provided within the time frames contained in Section 2.2(a) whether the claim or request is approved or denied for Pre-Service Claims (including Urgent Pre-Service Claims).

(b) **Content of Notification**.

(1) **Adverse Benefit Determination.** Notice of an Adverse Benefit Determination will be provided in written or electronic form. For Urgent Pre-Service Claims, notification will be provided orally to the Claimant within the timeframe described above and written or electronic notification will be furnished not later than three (3) days after the oral notification. The notice will be provided in a culturally and linguistically appropriate manner in accordance with 29 CFR Section 2590.715-2719, to the extent such regulations are applicable to the Benefit.

The notification will include the following:

(i) information sufficient to identify the claim involved, including the date of service, the identity of the health care provider, the claim amount, and, to the extent required under PPACA, a statement of the availability, upon request, of the diagnosis and treatment codes (if any) and their corresponding meanings;

(ii) the specific reason(s) for the determination, including the denial code (if any) and its corresponding meaning;

(iii) a description of the Plan's standard, if any, used to make the determination;

(iv) reference to the specific Plan provision(s) on which the determination is based;

(v) a description of any additional material or information necessary to complete the claim and an explanation of why such information is necessary;

(vi) a description of the internal appeals and external review processes (if any) available under the Plan, including how to initiate an appeal and the procedures and time limits applicable to an appeal, and (if applicable) the right to bring suit under ERISA Section 502(a) after an appeal;

(vii) disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination, or a statement that such information was relied upon in making the Adverse Benefit Determination, which will be provided free of charge upon request;

(viii) if the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's circumstances, or a statement that such explanation will be provided free of charge upon request; and

(ix) to the extent required under PPACA, disclosure of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes (if any).

(2) **Not Adverse Decision.** For Pre-Service Claim and Urgent Pre-Service Claim determinations that are not adverse, notice that the request for prior authorization has been approved will be provided.

2.4 **Appeals Process.** The following will apply to all types of Adverse Benefit Determinations:

(a) **Right to Review Claim File**. The Claimant will have the right to review his or her claim file.

(b) **Submission and Consideration of Comments**. To the extent required under PPACA, the Claimant will have the right to present "evidence and testimony" to the extent required by, and in accordance with, PPACA. Regardless of whether PPACA requires the right to present "evidence and testimony," the Claimant will have the opportunity to submit documents, written comments, or other information in support of the appeal. The review of the Adverse Benefit Determination will take into account all information, whether or not presented or available for the initial determination. No deference will be given to the prior determination.

(c) **Disclosure of New or Additional Evidence**. The Claimant will be provided, without charge and as soon as possible, and sufficiently in advance of the date on which the notice of a final internal Adverse Benefit Determination is required to be provided, in order to give the Claimant a reasonable opportunity to respond prior to that date, any new or additional evidence considered, relied upon, or generated by or at the direction of the Plan in connection with the claim, to the extent required by, and in accordance with, PPACA.

(d) **Disclosure of New or Additional Rationale**. Before the Plan can issue a final internal Adverse Benefit Determination based on a new or additional rationale, the Claimant will be provided, without charge and as soon as possible, and sufficiently in advance of the date on which the notice of a final internal Adverse Benefit Determination is required to be provided, in order to give the Claimant a reasonable opportunity to respond prior to that date, any new or additional rationale for the Adverse Benefit Determination, to the extent required by, and in accordance with, PPACA.

(e) **Decision**. The review will be made by a named fiduciary and a person different from the person who made the prior determination and such person will not be a subordinate of the prior decision maker.

(f) **Consultation with Independent Medical Expert.** In the case of a claim denied on the grounds of a medical judgment, a healthcare provider with appropriate training and experience in the field of medicine involved in the medical judgment will be consulted. The healthcare provider who is consulted on appeal will not be the individual who was consulted, if any, during the prior determination or a subordinate of that individual.

(g) **Identification of Medical or Vocational Experts.** The claims process will provide for the identification 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.

2.5 **Filing an Appeal.** If there is an Adverse Benefit Determination, the Claimant may request a review by the Plan by filing an appeal.

(a) An appeal request must be in writing and submitted to the Plan, except for expedited reviews of Urgent Pre-Service Claims under the Plan. A Claimant may request such an expedited review orally or in writing and all necessary information (including the Plan's determination on review) will be transmitted by telephone, facsimile, or other available expeditious method.

(b) An appeal must include the following information:

(1) the name of the Plan;

(2) the identity of the Claimant, including name, address, and date of birth;

(3) information regarding the claim request being appealed, such as:

(i) for Post-Service Claims, a copy of the Explanation of Benefits or the claim number listed on the Explanation of Benefits; and

(ii) for other types of claims, a copy of the Adverse Benefit Determination notice that the Claimant received, or other information to identify the claim;

(4) a statement that the Claimant is requesting an appeal;

(5) an explanation of why an appeal is being requested, including the particular aspect of the Adverse Benefit Determination the Claimant is disputing; and

(6) supporting documentation.

(c) An appeal of an Adverse Benefit Determination must be submitted to the Plan within one hundred eighty (180) days following receipt of a notification of an Adverse Benefit Determination of a claim. If an appeal is not requested within this one hundred and eighty (180) day time period, the Claimant loses the right to appeal.

2.6 **Timeframes for Appeal Determinations.** A Claimant may voluntarily agree to extend the timeframes specified below to make a decision.

(a) **Post-Service Claims**. The Plan will make a determination within a reasonable period of time not to exceed sixty (60) days from the date the appeal was received.

(b) **Pre-Service Claims**. The Plan will make a determination within a reasonable period of time not to exceed thirty (30) days from the date the appeal was received.

(c) **Urgent Pre-Service Claims**. The Plan will make a determination as soon as possible, but no later than seventy-two (72) hours from the date the appeal was received.

(d) **Concurrent Care Claims**.

(1) For an appeal of a reduction or termination of coverage for a previously approved ongoing course of treatment, the Plan will make a determination before the course of treatment is reduced or terminated.

(2) Where an extension is requested by the Claimant for coverage beyond the initially approved Benefit, and

(i) If the request meets the definition of an Urgent Pre-Service Claim, the Plan will make a determination as soon as possible, but no later than seventy-two (72) hours from the date the appeal was received.

(ii) If the request does not meet the definition of an Urgent Pre-Service Claim, the Plan will make a determination within a reasonable period of time not to exceed thirty (30) days from the date the appeal was received.

2.7 **Notification of Appeal Decisions.**

(a) **Timeframe and Notification**. Written or electronic notification of the Plan's determination will be provided to the Claimant for all appeals within the time frames contained in Section 2.6. The notification will be provided in a culturally and linguistically appropriate manner in accordance with 29 CFR Section 2590.715-2719, to the extent such regulations are applicable to the Benefit.

(b) **Content of Notification**.

(1) **Adverse Benefit Determination.** The notification will include the following:

(i) information sufficient to identify the claim involved, including the date of service, the identity of the health care provider, the claim amount, and, to the extent required under PPACA, a statement of the availability, upon request, of the diagnosis and treatment codes (if any) and their corresponding meanings;

(ii) a discussion of the Adverse Benefit Determination, including the specific reason(s) for the determination, the denial code (if any) and its corresponding meaning, and the Plan's standard, if any, used to make the determination;

(iii) reference to the specific Plan provision(s) on which the determination is based;

(iv) a description of the External Review process (if any) available under the Plan;

(v) a statement indicating entitlement to receive, upon request and free of charge, reasonable access to or copies of all documents, records and other information relevant to the Claimant's claim for benefits;

(vi) a statement regarding additional levels of appeal (if any) and the right to sue in federal court;

(vii) disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination, or a statement that such information will be provided free of charge upon request;

(viii) if the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's circumstances, or a statement that such explanation will be provided free of charge upon request; and

(ix) a disclosure of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the external review process (if any).

(2) **Not Adverse Decision.** Notice will be provided informing the Claimant that the decision has been reversed and the claim has been approved or, under the Plan, a Pre-Service Claim has been approved.

2.8 **External Review.** PPACA requires External Review be made available in certain circumstances under applicable state or federal procedures. In addition, PPACA requires an expedited External Review be made available under certain circumstances. The Plan will provide External Review, including expedited External Review, to the extent required by, and in accordance with, PPACA. External Review decisions are binding on the Plan and Claimant except to the extent other remedies are available under applicable state and/or federal law.

ARTICLE III. CLAIMS AND APPEAL PROCEDURES FOR DISABILITY BENEFITS

3.1 **Purpose.** This Article III shall apply with respect to benefits, regardless of the Component under which they are provided, that constitute disability benefits for purposes of 29 C.F.R. § 2560.503-1, to the extent a Coverage Contract governing such benefits does not contain a claims and claims appeal procedure compliant with ERISA. Accordingly, this Article III may apply to claims for benefits under the disability component(s) of the Plan and under any other component of this Plan where the claim is a claim for disability benefits under the Plan.

3.2 **Benefit Determination and Denial.**

(a) The Plan shall notify a Claimant within a reasonable period of time not to exceed forty-five (45) days after receipt of a written claim for benefits of the Claimant's eligibility, or non-eligibility, for benefits under the Plan. If it is determined that a person is not eligible for benefits, or for full benefits, the notice shall set forth, effective April 1, 2018, in a culturally and linguistically appropriate manner in accordance with 29 CFR Section 2560.503-1(o), as follows:

(1) the specific reason(s) for the determination;

(2) reference to the specific Plan provision(s) on which the determination is based;

(3) a description of any additional material or information necessary to complete the claim and an explanation of why such information is necessary;

(4) a description of the Plan procedures and time limits for appeal of the Adverse Benefit Determination and the right to bring suit under ERISA § 502(a) after an appeal;

(5) effective April 1, 2018, a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination, without regard to whether the advice was relied upon in making the decision; and

(iii) a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration;

(6) disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination, or a statement that such information was relied upon in making the Adverse Benefit Determination, which will be provided free of charge upon request; and

(7) if the Adverse Benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment 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.

(b) If the Plan determines that there are matters beyond the control of the Plan requiring additional time to make a decision, the Plan shall notify the Claimant of the matters and the date by which a decision is expected to be made, and may extend the time for up to two (2) additional thirty (30) day periods. In that case, the Plan will notify the Claimant of the need for such an extension prior to the end of the initial forty-five (45) day review period in the case of the first 30-day extension and, if a second 30-day extension is required, prior to the end of the first 30-day extension. If the reason for the extension is the failure to provide necessary information and the Claimant is

appropriately notified, the Plan's period of time to make a decision is "tolled." Tolling means the period of time in which the Plan must determine a claim is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the Claimant responds. For this purpose, notification can be made orally to the Claimant or the health care professional, unless the Claimant requests written notice. The notification will include a time frame in which the necessary information must be provided (which shall be at least forty-five (45) day in duration). Once the necessary information has been provided, the Plan must decide the claim within the extension described above. If the requested information is not provided within the time specified, the claim may be decided without that information.

3.3 **Appeal Process.** The following will apply to Adverse Benefit Determinations:

(a) **Submission and Consideration of Comments.** The Claimant will have the opportunity to submit documents, written comments, or other information in support of the appeal. The review of the Adverse Benefit Determination will take into account all information, whether or not presented or available for the initial determination. No deference will be given to the prior determination.

(b) **Disclosure of New or Additional Evidence.** The Claimant will be provided, without charge and as soon as possible, and sufficiently in advance of the date on which the notice of a final internal Adverse Benefit Determination is required to be provided, in order to give the Claimant a reasonable opportunity to respond prior to that date, any new or additional evidence considered, relied upon, or generated by or at the direction of the Plan in connection with the claim, to the extent required by, and in accordance with, ERISA.

(c) **Disclosure of New or Additional Rationale.** Before the Plan can issue a final internal Adverse Benefit Determination based on a new or additional rationale, the Claimant will be provided, without charge and as soon as possible, and sufficiently in advance of the date on which the notice of a final internal Adverse Benefit Determination is required to be provided, in order to give the Claimant a reasonable opportunity to respond prior to that date, any new or additional rationale for the Adverse Benefit Determination, to the extent required by, and in accordance with, ERISA.

(d) **Decision.** The review will be made by a named fiduciary and a person different from the person who made the prior determination and such person will not be a subordinate of the prior decision maker.

(e) **Consultation with Independent Medical Expert.** In the case of a claim denied on the grounds of a medical judgment, a healthcare provider with appropriate training and experience in the field of medicine involved in the medical judgment will be consulted. The healthcare provider who is consulted on appeal will not be the individual who was consulted, if any, during the prior determination or a subordinate of that individual.

(f) **Identification of Medical or Vocational Experts.** The claims process will provide for the identification 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.

3.4 **Filing an Appeal.** If a Claimant is determined by the Plan not to be eligible for benefits, or if the Claimant believes that he or she is entitled to greater or different benefits, the Claimant shall have the opportunity to have the claim reviewed by the Plan by filing a petition for review within one hundred eighty (180) days after receipt by the Claimant of the notice issued by the Plan. That petition shall state the specific reason(s) the Claimant believes he or she is entitled to benefits, or greater or different benefits.

3.5 **Appeal Determination.**

(a) Within a reasonable period of time not to exceed forty-five (45) days after receipt of that petition, the Plan shall afford the Claimant (and the Claimant's counsel, if any) an opportunity to present the Claimant's position to the Plan orally or in writing, and the Claimant (or the Claimant's counsel)

shall have the right to review the pertinent documents. The Plan shall notify the Claimant of its decision in writing within said forty-five (45) day period, stating specifically the basis of said decision, written in a manner calculated to be understood by the Claimant, and the specific provisions of the Plan on which the decision is based. In the event of the death of a Claimant, the same procedure shall be applicable to the Claimant's beneficiaries. For adverse appeal determinations, the notification shall reflect, effective April 1, 2018, in a culturally and linguistically appropriate manner in accordance with 29 CFR Section 2560.503-1(o), at least the following:

(1) the specific reason(s) for the Adverse Benefit Determination;

(2) reference to the specific Plan provision(s) on which the determination is based;

(3) a statement indicating entitlement to receive, upon request and free of charge, reasonable access to or copies of all documents, records and other information relevant to the Claimant's claim for benefits;

(4) a statement regarding additional levels of appeal (if any) and the right to bring suit under ERISA § 502(a) and, effective April 1, 2018, 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;

(5) effective April 1, 2018, a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination, without regard to whether the advice was relied upon in making the decision; and

(iii) a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration;

(6) disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination or a statement that such information will be provided free of charge upon request; and

(7) if the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment 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.

Notice of the adverse determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with applicable legal requirements.

(b) If the Plan determines that there are special circumstances requiring additional time to make a decision, the Plan shall notify the Claimant of the matters and the date by which a decision is expected to be made, and may extend the time for up to forty-five (45) days.

ARTICLE IV. CLAIMS AND APPEAL PROCEDURES FOR OTHER BENEFITS

4.1 **Purpose.** This Article IV shall apply with respect to benefits that (1) are provided under a Component that does not constitute a group health plan for purposes of 29 C.F.R. § 2560.503-1, and (2) do not constitute disability benefits for purposes of 29 C.F.R. § 2560.503-1, to the extent a Coverage Contract governing such benefits does not contain a claims and claims appeal procedure compliant with ERISA.

4.2 **Benefit Determination and Denial.**

(a) The Plan shall notify a Claimant within a reasonable period of time not to exceed ninety (90) days after receipt of a written claim for benefits of the Claimant's eligibility, or non-eligibility, for benefits under the Plan. If it is determined that a person is not eligible for benefits, or for full benefits, the notice shall set forth as follows:

(1) the specific reason(s) for the determination;

(2) reference to the specific Plan provision(s) on which the determination is based;

(3) a description of any additional material or information necessary to complete the claim and an explanation of why such information is necessary; and

(4) a description of the Plan procedures and time limits for appeal of the Adverse Benefit Determination and the right to bring suit under ERISA § 502(a) after an appeal.

(b) If the Plan determines that there are special circumstances requiring additional time to make a decision, the Plan shall notify the Claimant of the special circumstances and the date by which a decision is expected to be made, and may extend the time for up to an additional ninety (90) days.

4.3 **Appeal Process.**

(a) If a Claimant is determined by the Plan not to be eligible for benefits, or if the Claimant believes that he or she is entitled to greater or different benefits, the Claimant shall have the opportunity to have the claim reviewed by the Plan by filing a petition for review within sixty (60) days after receipt by the Claimant of the notice issued by the Plan. That petition shall state the specific reasons the Claimant believes he or she is entitled to benefits or greater or different benefits. Within a reasonable period of time not to exceed sixty (60) days after receipt of that petition, the Plan shall afford the Claimant (and the Claimant's counsel, if any) an opportunity to present the Claimant's position to the Plan orally or in writing, and the Claimant (or the Claimant's counsel) shall have the right to review the pertinent documents. The Plan shall notify the Claimant of its decision in writing within said sixty (60) day period, stating specifically the basis of said decision written in a manner calculated to be understood by the Claimant and the specific provisions of the Plan on which the decision is based. In the event of the death of a Claimant, the same procedure shall be applicable to the Claimant's beneficiaries.

For adverse appeal determinations, the notification shall reflect at least the following:

(1) the specific reason(s) for the Adverse Benefit Determination;

(2) reference to the specific Plan provision(s) on which the determination is based;

(3) a statement indicating entitlement to receive, upon request and free of charge, reasonable access to or copies of all documents, records and other information relevant to the Claimant's claim for benefits; and

(4) a statement regarding additional levels of appeal (if any) and the right to bring suit under ERISA § 502(a).

Notice of the adverse determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with applicable legal requirements.

(b) If the Plan determines that there are special circumstances requiring additional time to make a decision, the Plan shall notify the Claimant of the matters and the date by which a decision is expected to be made, and may extend the time for up to sixty (60) days.