Your Benefit Program

Highlights

At Turner, we value your hard work, and we believe you deserve a high-quality, comprehensive benefit program. Turner Benefits offers you and your family the opportunity to enjoy a cost-efficient approach to health and insurance protection, as well as a retirement program that will help you plan for the future. You have the opportunity to enroll in Turner Benefits when you first become eligible and again each year during the Open Enrollment period. Turner offers the following benefit plans:

- Medical (includes prescription drug coverage, Mental Health Services, and Substance Use Disorder Services).
- Health Support Program – Healthy Me
- Employee Assistance Program
- Dental Assistance Plan
- Vision Care
- Flexible Spending Accounts
- Life Insurance
- Accidental Death & Dismemberment (AD&D)
- Business Travel Accident
- Short Term Disability
- Long Term Disability
- Turner Retirement Investment Plan (TRIP)

The benefit options you choose at enrollment will remain in effect throughout the calendar year. You may not make any changes to your benefit choices until the next Open Enrollment period — unless you experience a qualifying change in status or qualify for a “special enrollment” period (see pages 5-6). **Unless otherwise noted, this SPD is generally effective as of January 1 of each year.**

Whether you choose to enroll in benefit options now or in the future, you should keep this Summary Plan Description (SPD) in a convenient place. It provides the answers to many questions you may have about your benefits. If you have additional questions, you may call the Benefits Service Center at the number listed in your Contact Directory.

Please refer to the **Administrative Information** section of this Summary Plan Description for additional information on claims procedures, plan administration, your rights under the plan, and Turner's rights under the plan, including the ability to amend or terminate the plan or any component of it at any time in accordance with applicable law and the discretion to interpret all plan documents and make factual determinations. If there is a conflict between this Summary Plan Description and the official plan documents, the plan documents will govern.
Eligibility

Employee

If you are a regular, salaried, Turner employee who is regularly scheduled to work at least 20 hours per week, you automatically receive Business Travel Accident Insurance and Basic Life Insurance coverage on your first day of employment. You are eligible for the following Health & Welfare benefits effective the first of the month following or coincident with your date of hire:

- Medical
- Health Support Program – Healthy Me
- Employee Assistance Program
- Dental
- Vision
- Flexible Life
- Dependent Life
- Long Term Disability
- Accidental Death & Dismemberment
- Flexible Spending Accounts

In addition, you become eligible for Short Term Disability coverage after three months of service with Turner.

You are eligible for the Turner Retirement Investment Plan (TRIP) — the main component of the Turner Wealth Accumulation Program — if you are actively employed as a salaried employee and you are not:

- Covered by a collective bargaining agreement (unless the agreement provides for plan participation)
- A non-resident with no U.S. source of income
- A leased employee
- A temporary employee (including those employed under a cooperative program) who has not completed a 1-year period of service (see page 119), or
- An employee under an international employment program whose employment arrangement does not provide for participation in the Turner Retirement Investment Plan.

As an eligible employee, you are automatically enrolled in the TRIP on the first day of the month following or coincident with the later of:

- Your 21st birthday
- Your date of hire

Dependents

You may also enroll your eligible dependents in the following benefit programs:

- Medical
- Dental
- Vision
- Dependent Life Insurance
- Accidental Death & Dismemberment (AD&D)

Your eligible dependents include:

- Your spouse (including common law spouse as defined by law in your state of residence)
- Your Registered Domestic Partner (see page 6)
• Your unmarried dependents children, stepchildren (provided they live with you), legally adopted children, children for whom legal guardianship has been awarded to you or your spouse, and the children of your Registered Domestic Partner (provided they live with you), until the end of the month of their 19th birthday for dental and vision.

• Your unmarried dependent children, from age 19 to the end of the month of their 25th birthday, who are full-time students and primarily dependent on you for support and maintenance. The child must not be regularly employed on a full-time basis. You will periodically be required to submit proof of full-time student status for dental and vision.

• Your married or unmarried dependent children, stepchildren, legally adopted children, children for whom legal guardianship has been awarded to you or your spouse, and the children of your Registered Domestic Partner are covered until the end of the month of their 26th birthday for medical coverage only.

• Your unmarried dependent children who become physically or mentally disabled while covered and remain disabled, regardless of current age (see below).

• A child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

Registered Domestic Partners may be covered under the Flexible Spending Account Plan only if they meet the IRS’s definition of “dependent” for tax purposes. Generally, the following conditions must be met in order for your Registered Domestic Partner to qualify as your tax dependent for health coverage purposes under federal tax law:

• You and your Registered Domestic Partner have the same principal place of abode for the entire calendar year.

• Registered Domestic Partner is a member of your household for the entire calendar year (the relationship must not violate local law).

• During the calendar year you provide more than half of the total support for your Registered Domestic Partner.

• Your Registered Domestic Partner is not your (or anyone else’s) “qualifying child” under Section 152(c) of the Internal Revenue Code, and

• Your Registered Domestic Partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada, or Mexico.

• If your Registered Domestic Partner is not also your “dependent” for federal tax purposes, you will be imputed income (meaning the amount shown as your gross income on your form W-2 will be higher than the amount of your wages) for the portion of the coverage that Turner pays for to cover your Registered Domestic Partner and your portion of the cost of coverage for your Registered Domestic Partner will be paid on an after-tax basis.

For additional information on tax dependent status for Registered Domestic Partners and their children, please contact the Benefits Service Center or your tax advisor.

In addition, your spouse or Registered Domestic Partner is eligible to participate in the Health Support Program – Healthy Me (see page 60).

Coverage for Disabled Dependents

If you have a physically or mentally disabled child who is beyond the dependent eligibility age, you may be eligible to cover or continue medical, dental, and/or vision coverage for that child. The child must be incapable of self-support. (A child with a learning disability is not considered physically or mentally disabled.) You must provide proof of continuing disability to the Benefits Service Center.

You may continue coverage for a disabled child until the earliest of the following events:

• Your coverage under the plan ends

• The child’s disability ends

• You fail to provide proof when requested that the disability continues

• Your disabled child fails to undergo any physical examination required as proof of continuing disability.
For more information regarding disabled dependents, please call the Benefits Service Center.

**Qualified Medical Child Support Order**

Turner plans will comply with the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order or judgment from a state court — served on the company or the agent for service of legal process — directing the Plan Administrator to cover a child for benefits under the health care plans.

To qualify as a QMCSO, it must:

- State the name and last known mailing address of the employee and each child covered by the order
- Give a reasonable description of the type of coverage or benefits the plan must provide for each covered child
- Specify the period of time to which the order applies
- Clearly identify each plan to which the order applies

A QMCSO does not require the plan to provide a benefit or form of benefit — standard or optional — that is not otherwise provided for under the plan as of the effective date of the order.

When the company receives a QMCSO, the employee and each child covered is notified of the order’s receipt, the procedure used to determine if the order is qualified and whether or not it qualifies. The Plan Administrator will add dependents and adjust contributions as required to comply with a qualified QMCSO.

**Removing Dependents from Coverage**

It is your responsibility to contact the Benefits Service Center to remove ineligible dependents from coverage within 30 days from the date the dependent becomes ineligible. Until you do so, you will continue to pay for coverage, even if the plan cancels coverage for that dependent. Cancellation is effective at the end of the month during which he or she becomes ineligible. No refunds will be made for premiums paid for an ineligible dependent if you did not notify the Benefits Service Center within 30 days of the date the dependent became ineligible.

**If You and Your Spouse Both Work for Turner**

If you are eligible, you may choose coverage as an employee or as a dependent of another employee, but not both. Children can be covered as dependents of only one employee. For example, if you and your spouse both work for Turner, you would have the following options:

- Each of you may be covered separately as employees and one of you may elect to cover any eligible dependent children
- One of you may waive coverage and be covered as a dependent, along with any eligible children, under the other spouse’s coverage, or
- Each of you may waive coverage

**Participation**

**Enrollment**

**New Hire Enrollment**

After you become eligible for Turner Benefits, enrollment information and instructions will automatically be mailed to your home address. **You must make your elections within 31 days of your eligibility date.**

Once you enroll, you generally cannot change your choices until the next Open Enrollment period — unless you have a qualified change in status (see page 6) or qualify for a “special enrollment” period as described on page 5.

**Open Enrollment**

You have the opportunity to change your benefit elections each year during Open Enrollment. The Open Enrollment period typically occurs in the Fall for coverage that will be effective the following January.

Before the Open Enrollment period begins, you will receive materials to help you make your benefit choices and complete the enrollment process. Please review this information and contact the Benefits Service Center with any questions.
Once you have completed your benefit choices, you will not be able to make any changes to your coverage until the next Open Enrollment period — unless you have a qualified change in status or qualify for a “special enrollment period” (see pages 5-6).

**Evidence of Insurability**

You may be required to provide Evidence of Insurability when you first enroll in Supplemental Life Insurance or Dependent Life Insurance. You may also be required to provide Evidence of Insurability if you increase your level of coverage or if the change is due to a qualified change in status (see page 6).

To provide Evidence of Insurability, you’ll need to complete a form that contains questions about the health and medical history of the person to be insured. Visit [www.turnerbenefits.com](http://www.turnerbenefits.com) via TKN and then My Turner Benefits to complete the form online and submit it directly to our Life Insurance carrier.

**Special Enrollment Rights**

Special enrollment rights allow you and/or your dependents to enroll in health coverage without waiting until Open Enrollment if certain events occur. You have only 30 days after the event occurs to request special enrollment.

**Other Coverage**

If you decline coverage because you or your dependents have group health coverage elsewhere, you may be eligible for special enrollment if one of the following events occurs:

- You gain a dependent through marriage, birth, adoption, or placement for adoption
- You and/or your dependents lose eligibility for other group health coverage for reasons including:
  - Legal separation
  - Divorce
  - Death
  - Termination of employment
  - Reduced work hours
- The employer contributions to the other group health coverage stop
- The other coverage was COBRA coverage and the maximum COBRA coverage period ends (see page 177)
- You and/or your dependents have coverage terminated under Medicaid or a state children's health insurance program (CHIP) due to a loss of eligibility (you have 60 days, instead of 30 days, to enroll in a company health care plan under this special enrollment right)
- You and/or your dependents become eligible for group health plan premium assistance under Medicaid or CHIP (i.e., a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program; note that premium assistance is not mandatory and each state has its own provisions) (you have 60 days, instead of 30 days, to enroll in a company health care plan under this special enrollment right)

**Marriage**

Even if you are not currently enrolled in a Turner Benefits health care plan, you may enroll yourself and your new spouse within 30 days of your marriage. Coverage will be effective on the date of the marriage if you provide enrollment information to the Benefits Service Center within 30 days of the marriage.

**Birth, Adoption, or Placement for Adoption**

Even if you are not currently enrolled in a Turner Benefits health care plan, you may enroll yourself and your new child within 60 days of the birth, adoption, or placement with you for adoption, unless you are covered under a UPMC Health Plan, in which case you have 30 days to enroll. If your spouse is not enrolled in the plan, you may enroll him or her when you enroll your new child. Coverage is retroactive to the date of birth, adoption, or placement for adoption.
Making Changes During the Year (Qualified Change in Status)

Generally, once you make your benefit choices, you may not change them until the next Open Enrollment period. But there are some limited exceptions, described below. These exceptions may apply to all benefit elections.

If you believe you may fall within one of the limited exceptions and you need to change your election during the year, you must do so no later than 30 days after the event that causes the exception to occur. Turner Benefits determines eligibility for any change discussed in this section. Contact the Benefits Service Center as soon as possible to make the appropriate changes.

Family Events

You may change your benefit elections during the year if one of the following family events affects your eligibility, your spouse’s eligibility, or your dependent child’s eligibility with respect to that coverage. Any election change must be consistent with the family event allowing the change. Remember it is not enough just to have an event occur. The event must affect eligibility, and the election change must be consistent with that event.

Family events are:

- Your marriage, divorce, legal separation, legal annulment, or the death of your spouse
- Dissolution of a registered domestic partnership or the death of your Registered Domestic Partner
- Dissolution of common law marriage through a court proceeding
- Your dependent child’s birth, death, adoption, or placement with you for adoption
- Your dependent child becomes eligible or ineligible for coverage due to his or her age, student status, marital status, or any similar circumstance
- A change in your residence, your spouse’s residence, or your dependent’s residence that affects that person’s eligibility

Job Events

You may change your benefit elections during the year if one of the following job events affects your eligibility, your spouse’s eligibility, or your dependent child’s eligibility with respect to that coverage. Any election change must be consistent with the job event allowing the change. Remember it is not enough just to have an event occur. The event must affect eligibility, and the election change must be consistent with that event.

Job events are:

- A termination or commencement of employment
- A strike or lockout
- A commencement of or return from an unpaid leave of absence
- A change in worksite
- Any other change in employment status with the consequence that the person becomes or ceases to be eligible for a benefit

Qualified Medical Child Support Order

See page 4 for more information on this limited exception.

Family and Medical Leave Act (FMLA)

If you take FMLA leave, you may change your election with respect to medical, dental, or vision coverage. You may also change your Health Care Flexible Spending Account election. The election change must be consistent with the reason for your FMLA leave.

Cost Changes

For your Dependent Care Flexible Spending Account only, significant cost changes that may allow you to change your contributions include:

- Selecting a different dependent care provider
• Provider cost increases
• Increasing or decreasing the hours (and the cost) of the provider

These exceptions apply only if the dependent care provider is not your relative. You will, however, be able to make changes to your Dependent Care Flexible Spending Account if a relative becomes available to care for your child or if a relative who had been caring for your child is no longer able to do so during the year, resulting in an increase to your cost for dependent care.

Other “Cafeteria” Plans

If the employer of your spouse, former spouse, or dependent child offers a “cafeteria” or “Section 125” plan that has a period of coverage different from the calendar year or that allows the same election changes listed above, you may change your benefit election to correspond with an election or election change made under that other cafeteria plan. Your election change must be due to and must correspond with that other election. Also, the other cafeteria plan must allow this type of change.

Medicare or Medicaid

If you, your spouse, or your dependent child is enrolled in group health coverage and also becomes entitled to Medicare or Medicaid coverage (other than Medicaid coverage solely for pediatric vaccines), you may change your election to cancel or reduce group health coverage for that person. Similarly, if that person loses entitlement to Medicare or Medicaid (other than Medicaid coverage solely for pediatric vaccines), then you may change your election to begin or increase group health coverage for that person. You must provide proof of Medicare or Medicaid eligibility (or loss of eligibility) to the Benefits Service Center.

Loss of Certain Governmental Health Coverage

You may change your election to add group health coverage for yourself, your spouse, or your dependents if you or they lose group health coverage sponsored by a governmental or educational institution, including a state children’s health insurance program (SCHIP) under Title XXI of the Social Security Act, certain Native American health insurance programs, a state health benefits risk pool or a foreign government group health plan. However, you may not drop group health coverage during the year in favor of these governmental health programs.

When Your Coverage Can Be Rescinded

Your coverage can be rescinded based on your fraud or intentional misrepresentation of facts. Rescission involves the retroactive cancellation or discontinuance of your coverage. You will be given at least 30 days’ notice before your coverage is rescinded. Your failure to provide notices to the Benefits Service Center within the time periods specified in this document, such as the 30-day period following a dependent’s loss of eligibility, will be considered an intentional misrepresentation of facts.

Cost of Coverage

The company pays the full cost for some benefit coverages and a portion of the cost for others. You help share in this cost with your before-tax or after-tax contributions, as described in the chart on the following page.

Before-tax contributions are taken out of your paycheck before federal, Social Security and, in most cases, state taxes are deducted. In addition, FICA taxes are paid on 401(k) contributions under the TRIP. This provides you with a tax advantage, but also some restrictions.

Because you are making before-tax contributions, you cannot stop or change your coverage choices during the calendar unless you experience a qualified change in status or have a special enrollment right.

In addition, because before-tax contributions reduce your taxable income, there will be less money available for Social Security taxes. This means that your contributions to Social Security will be reduced. However, because the final amount of your Social Security benefits is based on your entire earnings history, this reduction in your Social Security contributions has little effect on your final Social Security benefits.
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<tr>
<th>Service</th>
<th>Paid in Full by the Company</th>
<th>Paid in Full by You</th>
<th>Cost/Contributions Shared Between You and the Company</th>
<th>Before-Tax Contributions</th>
<th>After-Tax Contributions</th>
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<td>Medical Benefits (including prescription drug coverage, Mental Health Services and Substance Use Disorder Services)</td>
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<td>Employee Assistance Program (EAP)</td>
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<td>Dental Benefits</td>
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<td>Vision Care Plan</td>
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<td>Short Term Disability Coverage</td>
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<td>Long Term Disability Coverage</td>
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<td>Flexible Life Insurance</td>
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<td>– Basic Life</td>
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<td>– Supplemental</td>
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<td>Dependent Life Insurance</td>
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<td>Accidental Death &amp; Dismemberment Insurance (AD&amp;D)</td>
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<td>Business Travel Accident Insurance</td>
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<td>Flexible Spending Accounts</td>
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<td>Legal Plan</td>
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<td>Turner Retirement Investment Plan (TRIP)</td>
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1 Contributions for Registered Domestic Partners will be taken on an after-tax basis only, unless these dependents meet IRS qualifications. Please refer to 3 for more information on tax dependent status for Registered Domestic Partners and their children.

2 The Company pays your dental coverage in full. You and the Company share the cost of dental coverage for dependents.

3 Per IRS regulations, imputed income will be reported for your LTD premiums and your total Flexible Life Insurance amounts in excess of $50,000. This amount will appear on your annual W-2 form.

4 The Company will match up to the first 5% of your pre-tax contributions based on your years of service. See page 134-135.
If You Take a Leave of Absence

You may continue your Turner Benefit coverage elections during a leave of absence, as long as you make any required payments.

- **If you are on a paid leave**, your deductions continue unless you notify the Benefits Service Center otherwise.
- **If you are on unpaid leave of absence**, you must make monthly after-tax payments for your benefit coverage directly to the Benefits Service Center. If you take an unpaid leave of absence, you will receive a benefits status letter and information from the Benefits Service Center.
- **If your leave is covered under the Family and Medical Leave Act (FMLA)**, the company will continue to share the cost of your health care coverage for up to 12 weeks in a 12-month period. You will continue to be responsible for the employee portion of the cost of coverage. If you are on a paid leave, your deductions continue unless you notify the Benefits Service Center. If your leave is unpaid, you must make your after-tax payments directly to the Benefits Service Center.
- **If your leave is due to Workers’ Compensation**, you will continue to be responsible for the employee cost of coverage. If you are on a paid leave, your deductions continue unless you notify the Benefits Service Center. If your leave is unpaid, you must make your after-tax payments directly to the Benefits Service Center.
- **If your leave is due to active military duty**, the following chart applies:

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<thead>
<tr>
<th>Benefit</th>
<th>Coverage</th>
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<tbody>
<tr>
<td>Medical, Dental, Vision, Flexible Spending Accounts, Legal</td>
<td>Coverage ends upon your active duty date.</td>
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<tr>
<td>Life Insurance (Basic, Supplemental and Dependent Coverage)</td>
<td>Coverage ends upon your active duty date.</td>
</tr>
<tr>
<td>AD&amp;D (Employee and Dependent)</td>
<td>Coverage continues up to 6 months; you may then convert to an individual policy. You must continue to pay premiums.</td>
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<tr>
<td>Long Term Disability</td>
<td>Coverage ends at the end of the month immediately following the month in which your leave of absence begins, as long as the premium is paid.</td>
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</table>

If you are still on leave of absence after six (6) months, the terms of your leave will be reviewed and your ability to return to work will be discussed with you. At this time, the Company may choose to extend your leave, request that you return to work, or terminate your employment. If termination from employment occurs, you will become eligible to continue your medical, dental and/or vision coverage and your participation in the Health Care Flexible Spending Account through COBRA (see page 173). You may also be eligible to continue Life and AD&D Insurance (see page 103).

If you elect to drop coverage during an unpaid leave of absence under the change in status rules (see page 6), your coverage ends on the last day of the month in which your unpaid leave of absence begins. If you do not elect to drop coverage, you will be required to pay the cost of your coverage. If you fail to make the required payments, your coverage will end the last day of the month in which your unpaid leave of absence began or the last day of the month in which you paid your premiums in full, whichever is later.

You may reinstate your coverage within 30 days of the date you return to work. Your coverage will begin the first of the month following your return to work, except for FMLA, after which coverage begins upon your return to work. Deductions for this coverage will begin on the first pay period possible.

For more information about a leave of absence, contact the Benefits Service Center.