

GTE CORPORATION

Actuarial Methods and Assumptions for January 1, 1993 Retiree Welfare Valuation

METHODS

**Service cost and accumulated
postretirement benefit
obligation**

Projected unit credit, allocated from date of hire to full
eligibility date

Full eligibility date

Varies depending on plan provisions. Example:

- For locations with retiree medical cost-sharing unrelated to retirement age or years of service, full eligibility age is the earliest retirement eligibility date.
- For the service-related retiree medical contribution schedule, the full eligibility age is related to years of service at retirement date.

For example:

- For an employee who is assumed to retire with 30 or more years of service, full eligibility age is the employee's age when he completes 30 years of service.
- For an employee who is assumed to retire with 25-29 years of service, full eligibility age is the employee's age when he completes 25 years of service.
- For "pay-related" retiree life insurance plans, full eligibility age is the assumed retirement date.
- For locations with company-provided coverage available only if retirement is on or after a certain age (age 60 or 62), full eligibility age is age 60 or 62.

**Market-related value of assets
(where applicable)**

Fair value

**Development of claim cost
assumptions**

Per capita claim cost assumptions are based upon an analysis of actual per capita claim costs for 1990, 1991 and 6 months of 1992, with projection to 1993. Additional details are in Exhibit A.

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METHODS (continued)

FAS #106 adoption date January 1, 1992 for GTE consolidated accounting purposes and for most non-Telops local accounting; January 1, 1993 for Telops entities (and for Directories, GTE Labs and Service Corp.) for local accounting.

Amortization of transition obligation The consolidated accounting results by legal entity immediately recognized the transition obligation in 1992. The results to be used for local basis accounting (where different than consolidated) amortize the transition obligation over 20 years.

ADJUSTMENTS

AG/CSC: The results shown include an addition \$16 million of APBO to reflect GTE's estimated portion (50% for 1993) of AG's obligation for post-1993 retirees and certain 1992 ERIP retirements.

ECONOMIC ASSUMPTIONS

General inflation	4.0%
Discount rate	8.0%
Return on plan assets (where applicable)	8.25%
Salary increase rate (for pay-related life insurance)	6.0%

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MEDICAL PLAN ASSUMPTIONS

Age-related per capita claim costs are provided in Exhibit A. The claim costs vary by company/unit as appropriate based upon historical results. Administrative expenses equal to 4% of assumed claims are included in the starting per capita costs.

Medical trend assumptions

<u>Year</u>	<u>Pre-65</u>		<u>Post-65</u>
	<u>All GTE and "Old" Contel Plans</u>	<u>"New" Contel Plans</u>	
1993	13.0%	11.2%	9.5%
1994	12.0	10.4	9.0
1995	11.0	9.6	8.5
1996	10.0	8.8	8.0
1997	9.2	8.1	7.6
1998	8.5	7.5	7.2
1999	7.9	7.0	6.9
2000	7.4	6.6	6.6
2001	7.0	6.3	6.4
2002	6.6	6.0	6.2
2003	6.3	5.7	6.1
2004 and later	6.0	5.5	6.0

The above trend assumptions for post-65 costs for the Medicare Supplement plan reflect the impact of Medicare physician payment reforms, which limit "balance billing" by physicians not accepting Medicare assignment. A nonparticipating physician may not bill a Medicare patient more than 109.25% of the Medicare "allowable charge."

The trend assumptions shown above are applied to net incurred claims cost. The rates to be shown for corporate footnote disclosure should be those applicable to gross eligible charges. For disclosure purposes, the "average" health care cost trend rates assumed might be described as averaging approximately 11% for 1993, grading to 6% for years 2004 and later.

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MEDICAL PLAN ASSUMPTIONS (continued)

- Increase in retiree/
spouse contributions**
- For plans with a post-65 contribution of \$120, no future increases in the contribution are assumed.
 - For certain groups for which retiree contributions are established as fixed dollar amounts, as indicated in the summaries of plan provisions, no future increases in the contributions are assumed.
 - For all others, contributions are expected to increase at the medical trend rate above.
- Increase in administrative
expenses**
- Administrative expenses are included in the starting per capita claim cost, and are assumed to increase at the medical trend rate.

DEMOGRAPHIC ASSUMPTIONS

Mortality 1983 Group Annuity Mortality Table

Sample life expectancies:

Age 60:
Male 19.9
Female 25.7

Age 65:
Male 16.0
Female 21.3

Retirement Same as for pension valuation. Approximate average retirement ages:

Nonunion 60
Telops union 61
Other union 63

Termination Same as for pension valuation

Disability None assumed

DEMOGRAPHIC ASSUMPTIONS (continued)

- Dependent status**
- Current retirees: Actual spouse data was used for current retirees. If spouse birthdate was not provided, wives were assumed to be 3 years younger than husbands.
 - Future retirees: Based upon analysis of GTE demographics as shown below:

Retirement <u>Age</u>	<u>Percent Married at Retirement</u>	
	<u>Male</u>	<u>Female</u>
Under 50	86%	66%
50 - 54	89	66
55 - 59	90	63
60 - 64	90	55
65 and over	90	45

Spouse's age (for future retirees)

Wives are three years younger than husbands.

Participation rates (medical)

For plans requiring contributions by the retiree/spouse, a percentage of future retirees/spouses are assumed to decline retiree medical coverage. Decreased participation is expected as the dollar amount of required contributions increases. See Exhibit B for details.

**LIFE INSURANCE
ASSUMPTIONS**

**"Cashout" election rate
for life insurance (where
available)**

For current retirees, life insurance amounts were not available in the data except for Government Systems and Contel retirees. For plans with a cashout option at retirement, an assumption was made to approximate the life insurance amounts currently in effect:

**Percentage of
insurance still in effect:**

- Nonunion 60%
- Union 70%

**Other life insurance
assumptions**

Life insurance amounts for current retirees were estimated if not provided in retiree data (85% of retirees). For pay-related life insurance, the amount of life insurance for current retirees was estimated by using current average salary levels and projecting back to the retirement date to estimate salary at retirement.

GTE CORPORATION

**Actuarial Assumptions for Forecast
for January 1, 1993 Retiree Welfare Valuation**

Claims experience	Costs increase according to valuation assumptions.
Demographic	Experience follows valuation assumptions.
Population	Constant number of active employees.
Asset return	Experience follows valuation assumptions.
Plan provisions	Current plan provisions were assumed to continue unchanged over the forecast period.
Future VEBA contributions	None assumed except for Government Systems retiree life insurance VEBA, for which future contributions are assumed to equal the service cost each year plus 15-year amortization of the 1/1/93 unfunded actuarial liability.

GTE CORPORATION

Data Sources and Development of Per Capita Medical Cost Assumptions for January 1, 1993 Retiree Welfare Valuation

SOURCES OF CLAIM DATA

For the GTE retiree medical plans:

- Summaries of numbers of covered participants and dependents and related incurred non-drug claims by claimant age groups within regions for 1990, 1991 and the first six months of 1992 (from Medstat database)
- Summaries of paid drug claims (both mail order and non-mail order) by claimant age groups within regions for 1990 - 1992 (from Travelers)

For the Contel retiree medical plan:

- Summaries of paid claims for 1991 and 1992 (excluding mail-order drugs) and numbers of covered participants, split between "old" and "new" plans
- Amount of mail-order drug claims were not available for 1991 and were estimated based on GTE experience

For the Hawaii retiree medical plan, summaries of paid claims for 1991 and 1992 and numbers of covered participants.

DEVELOPMENT OF PER CAPITA MEDICAL COST ASSUMPTIONS

For the GTE retiree medical plans:

- Historical experienced per capita claims cost were calculated by age group within region for 1990, 1991 and 1992 (non-drug experience for 1992 was annualized)
- Per capita claims costs were projected to 1993 separately from 1990, 1991 and 1992 experience, based on assumed trend
- 1993 per capita claims costs were developed as a weighted average of 1990, 1991 and 6 months 1992 experience (weights used were 33.3%, 41.7% and 25% respectively)

GTE Corporation
Data Sources and Development of
Per Capita Medical Cost Assumptions for
January 1, 1993 Retiree Welfare Valuation

For the GTE retiree medical plans: (continued)

- Per capita claims costs were increased by 4% to reflect administrative fees and reflected minor adjustments for apparent understatement of post-65 and spouses per capita costs
- Post-65 costs for retirees with a "carve out" approach to coordination of GTE benefits with Medicare (generally, post-1989 retirees) were established as 75% of those for "pre-1990" retirees to reflect the different approach to coordination of plan benefits with Medicare

For the Contel retiree medical plans:

- Experienced per capita claims costs on a "paid" basis were determined for the "old" plan for 1991 and 1992, and were then adjusted to an incurred basis.
- Per capita claims costs for the "old" plan were projected to 1993 based on assumed trend separately from the 1991 and 1992 experience, and were increased by 4% to reflect administrative expenses
- 1993 per capita claims costs were developed as a weighted average of projected 1993 costs based on 1991 and 1992 experience (weighting used was 40% and 60%, respectively)
- These "composite" old plan 1993 per capita costs were adjusted to produce separate rates for California/Nevada and all other locations
- Corresponding costs for the "new" plan(s) were developed as a percentage of those for the "old" plan, based on the relationship of expected or "ratebook" costs for the different plan designs

SOURCES OF DEMOGRAPHIC DATA

Demographic data was collected from several sources as of January 1, 1993 for the valuation. Retiree data for Contel was provided by the Retiree Benefit Center. All other retiree data (except Hawaii) was supplied by Travelers, and supplemented by information from Shareholder Services and Telops. For Hawaii, 1993 pension data was used, supplemented by approximately 300 additional assumed retirees (to match reported headcounts).

Data for active employees was provided by Shareholder Services, and was supplemented by additional information provided by Telops for GTE and Contel Telops employees.

GTE CORPORATION

**Per Capita Medical Cost Assumptions for
January 1, 1993 Retiree Welfare Valuation**

	<u>Age</u>	<u>Pre-1990 Retirees</u>		<u>Post-1989 Retirees</u>		<u>Applies to:</u>
		<u>Retiree</u>	<u>Spouse</u>	<u>Retiree</u>	<u>Spouse</u>	
SET A	<50	\$4,162	\$2,528	\$4,162	\$2,528	GTE Southwest Telops Headquarters GTE Supply
	50 - 54	4,578	2,780	4,578	2,780	
	55 - 59	5,053	3,069	5,053	3,069	
	60 - 64	5,945	3,611	5,945	3,611	
	65 - 69	1,260	789	945	592	
	70 - 74	1,361	852	1,021	639	
	75 - 79	1,462	915	1,096	686	
	80 - 84	1,562	978	1,172	734	
	85 +	1,663	1,041	1,247	781	
SET B	<50	\$2,846	\$1,919	\$2,846	\$1,919	All GTE North Companies GTE Northwest
	50 - 54	3,130	2,111	3,130	2,111	
	55 - 59	3,455	2,330	3,455	2,330	
	60 - 64	4,065	2,741	4,065	2,741	
	65 - 69	1,060	763	795	572	
	70 - 74	1,145	824	859	618	
	75 - 79	1,230	885	922	664	
	80 - 84	1,314	946	986	710	
	85 +	1,399	1,007	1,049	755	
SET C	<50	\$2,990	\$2,294	\$2,990	\$2,294	All GTE South Companies Data Services (GTEDS) Communications Corp (GTECC)
	50 - 54	3,289	2,523	3,289	2,523	
	55 - 59	3,631	2,785	3,631	2,785	
	60 - 64	4,272	3,277	4,272	3,277	
	65 - 69	1,172	996	879	747	
	70 - 74	1,266	1,076	949	807	
	75 - 79	1,360	1,155	1,020	867	
	80 - 84	1,453	1,235	1,090	926	
	85 +	1,547	1,315	1,160	986	

GTE Corporation
 Per Capita Medical Cost Assumptions for
 January 1, 1993 Retiree Welfare Valuation

EXHIBIT A
 (continued)

	<u>Age</u>	<u>Pre-1990 Retirees</u>		<u>Post-1989 Retirees</u>		<u>Applies to:</u>
		<u>Retiree</u>	<u>Spouse</u>	<u>Retiree</u>	<u>Spouse</u>	
SET D	< 50	\$4,416	\$2,946	\$4,416	\$2,946	GTE California GTE Alaska GTEL
	50 - 54	4,858	3,241	4,858	3,241	
	55 - 59	5,363	3,578	5,363	3,578	
	60 - 64	6,309	4,209	6,309	4,209	
	65 - 69	1,252	1,050	939	788	
	70 - 74	1,352	1,134	1,014	851	
	75 - 79	1,452	1,218	1,089	914	
	80 - 84	1,552	1,302	1,164	977	
	85 +	1,653	1,386	1,239	1,040	
SET E	< 50	\$2,100	\$1,680	\$2,100	\$1,680	GTE Hawaii
	50 - 54	2,310	1,848	2,310	1,848	
	55 - 59	2,550	2,040	2,550	2,040	
	60 - 64	3,000	2,400	3,000	2,400	
	65 - 69	550	440	550	440	
	70 - 74	594	475	594	475	
	75 - 79	638	510	638	510	
	80 - 84	682	546	682	546	
	85 +	726	581	726	581	
SET F	< 50	\$3,131	\$2,683	\$3,131	\$2,683	All Non-Telops Units: Electrical Products Government Systems Service Corp. Telecommunications Products & Services AG/CSC
	50 - 54	3,444	2,951	3,444	2,951	
	55 - 59	3,802	3,258	3,802	3,258	
	60 - 64	4,473	3,833	4,473	3,833	
	65 - 69	1,356	1,356	1,017	1,017	
	70 - 74	1,464	1,464	1,098	1,098	
	75 - 79	1,573	1,573	1,180	1,180	
	80 - 84	1,681	1,681	1,261	1,261	
	85 +	1,790	1,790	1,342	1,342	

GTE Corporation
 Per Capita Medical Cost Assumptions for
 January 1, 1993 Retiree Welfare Valuation

EXHIBIT A
 (continued)

	Age	California & Nevada		All Other Units		Applies to:
		Retiree	Spouse	Retiree	Spouse	
SET G	< 50	\$3,769	\$2,914	\$3,151	\$2,437	Contel "Old" Plans (Grandfathered plus pre-1989 retirees)
	50 - 54	4,146	3,206	3,467	2,680	
	55 - 59	4,576	3,539	3,827	2,959	
	60 - 64	5,384	4,163	4,502	3,481	
	65 - 69	1,403	1,146	1,174	959	
	70 - 74	1,515	1,238	1,268	1,036	
	75 - 79	1,627	1,329	1,362	1,112	
	80 - 84	1,740	1,421	1,456	1,189	
	85 +	1,852	1,513	1,550	1,266	
SET H	< 50	\$3,015	\$2,331	\$2,521	\$1,949	Contel "New" Plan High Option (see note below)
	50 - 54	3,317	2,564	2,773	2,144	
	55 - 59	3,661	2,831	3,061	2,367	
	60 - 64	4,307	3,330	3,602	2,785	
	65 - 69	1,389	1,135	1,162	949	
	70 - 74	1,500	1,225	1,255	1,025	
	75 - 79	1,611	1,316	1,348	1,101	
	80 - 84	1,722	1,407	1,441	1,177	
	85 +	1,833	1,498	1,534	1,253	
SET I	< 50			\$2,994	\$2,315	Applies to: post-3/1/93 union retirees of Contel New York and Vermont
	50 - 54			3,293	2,546	
	55 - 59			3,635	2,811	
	60 - 64			4,277	3,307	
	65 - 69			822	671	
	70 - 74			888	725	
	75 - 79			954	778	
	80 - 84			1,019	832	
	85 +			1,085	886	

Note: Assumed costs for "new" plan middle and low options were a percentage of the above costs for the high option, as follows:

	Percent of High Option Cost
Middle Option	
• Pre-65	93.0%
• Post-65	99.5%
Low Option	
• Pre-65	86.0%
• Post-65	99.0%

GTE CORPORATION

**Medical Plan Participation Rates for
Future Retirees for
January 1, 1993 Retiree Welfare Valuation**

Participation rate assumptions generally vary based upon the level of contributions required by the retiree or spouse:

**Service-Related Contribution
Schedule (except EPG)**

<u>Years of Service at Retirement</u>	<u>Percent Participation</u>	
	<u>Retiree</u>	<u>Spouse</u>
0 - 9	73%	67%
10 -14	73	67
15 -19	82	78
20 -24	91	89
25 -29	96	94
30 +	98 *	97 *

* For GTE Labs, 96% for retiree and 94% for spouse.

**Service-Related Contribution
Schedule (for EPG)**

<u>Years of Service at Retirement</u>	<u>Retiree</u>	<u>Spouse</u>
0 -14	73%	67%
15 -19	78	73
20 -24	87	83
25 -29	94	91
30 +	98	97

GTE Telops Alaska

<u>Age at Retirement</u>	<u>Retiree</u>	<u>Spouse</u>
Under 65	90%	80%
65 and Over	97	96

GTE Supply Non-union

<u>Age at Retirement</u>	<u>Retiree</u>	<u>Spouse</u>
Under 65	93%	87%
65 and Over	97	96

GTE Corporation
 Medical Plan Participation Rates for
 Future Retirees for January 1, 1993
 Retiree Welfare Valuation

EXHIBIT B
 (continued)

**GTE Telops South Union and Telops
 Ohio Union**

<u>Age at Retirement</u>	<u>Retiree</u>	<u>Spouse</u>
Under 65	97%	93%
65 and Over	97	96

**GTE California Union and
 GTEL Union**

<u>Age at Retirement</u>	<u>Retiree</u>	<u>Spouse</u>
Under 60	90%	80%
60 - 64	100	94
65 and Over	100	97

**GTE Hawaii Union and all Contel
 Union and Non-union**

-----100% participation-----

**GTE Telops Union at Indiana CWA,
 and Pennsylvania (also pre-1994
 Wisconsin and Northwest Union)**

<u>Age at Retirement</u>	<u>Retiree</u>	<u>Spouse</u>
Under 62	90%	80%
62 - 64	100	99
65 and Over	100	97

**GTE Telops Union at Illinois, Indiana
 IBEW, Michigan, Midwest (IA, MN,
 MO, NE), Northwest, and
 Wisconsin**

<u>Age at Retirement</u>	<u>Retiree</u>	<u>Spouse</u>
Under 60	90%	80%
60 - 64	100	99
65 and Over	100	97

**GTE Supply Union and
 AG Communication**

	<u>Retiree</u>	<u>Spouse</u>
Male	85%	50%
Female	75	80

THE PLAN FOR BARGAINED RETIRED GROUP INSURANCE

SECTION 1. ESTABLISHMENT

1.01. The Establishment of the Plan.

GTE Corporation has established, a plan, effective September 30, 1991 (Plan No. 504), as hereinafter set forth for providing medical benefits to eligible retired employees and their dependents. The plan, as stated herein and as amended from time to time, shall be known as The Plan for Bargained Retired Group Insurance.

1.02. Component Benefits.

The Plan shall include those Component Benefits provided under the designations listed in Schedules A and B.

SECTION 2. DEFINITIONS**2.01. Definitions.**

- (a) The following words and phrases as used in the Plan shall have the following meanings unless a different meaning is required by the context:
- (1) **Committee.** The term "Committee" means the Employee Benefits Committee of the Company.
 - (2) **Company.** The term "Company" means GTE Service Corporation, a New York corporation.
 - (3) **Component Benefit.** The term "Component Benefit" means an employee welfare benefit that is designated on Schedule A as one of the component benefits of the Plan or a description of such benefit as set forth in an applicable Plan document.
 - (4) **Employer.** The term "Employer" means any employer that is an affiliate of GTE and that has joined in the Trust Agreement as an Associate, as defined in the Trust Agreement.
 - (5) **ERISA.** The term "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.
 - (6) **GTE.** The term "GTE" means GTE Corporation, a New York corporation.
 - (7) **Plan.** The term "Plan" means The Plan for Bargained Retired Group Insurance as set forth herein, including all exhibits, schedules, appendices and supplements hereto and all documents incorporated herein by reference, as each is amended from time to time.
 - (8) **Qualified Medical Child Support Order.** The term "Qualified Medical Child Support Order" shall mean any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which meets the requirements of Section 609(a) of ERISA and which: (i) provides for child support with respect to a child of a participant under the Plan or provides for the health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under the Plan, or (ii) enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to the Plan.
 - (9) **Trust.** The term "Trust" means the trust created by the Trust Agreement.
 - (10) **Trust Agreement.** The term "Trust Agreement" means the agreement between the Company and State Street Bank and Trust Company.

dated and effective as of September 30, 1991, as amended from time to time, and any successor thereto. The Trust Agreement is hereby incorporated by reference into and made a part of, the Plan.

(11) Trustee. The term "Trustee" means the trustee of the Trust.

(12) Year. The term "Year" means the fiscal year of the Plan commencing January 1 and ending December 31.

(b) Gender. When used in the Plan, masculine pronouns shall refer both to males and to females.

SECTION 3. BENEFITS

3.01. Coverage and Benefits.

- (a) The retired employees covered and the benefits provided by each Component Benefit shall be determined exclusively by the summary plan description for that Component Benefit; provided, however, that coverage and benefits under the Plan shall be provided in excess of such as may be provided by the summary plan description for a Component Benefit to the extent required by applicable law.
- (b) Notwithstanding the foregoing in subparagraph (a), effective August 9, 1993, the Plan shall provide benefits to dependent children planned with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries under the Plan, irrespective of whether the adoption has become final; and the Plan shall not restrict coverage of such a child solely on the basis of preexisting condition of such child at the time that such child would otherwise become eligible for coverage under the Plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the Plan, in accordance with Section 609(c) of ERISA and the regulations thereunder.

3.02. Payment of Benefits.

Benefits provided by the Component Benefits shall be paid by the Plan. The liability of the Plan, the Trust and the Trustee to provide benefits under a Component Benefit shall be limited by the terms of the Component Benefit summary plan description, the Trust Agreement, and this Plan instrument.

3.03. Tax Withholding.

The amount of any benefit paid from the Plan to a participant or beneficiary under a Component Benefit shall be reduced by the amount of any income tax or employment tax that is required to be withheld pursuant to any applicable federal, state, or local law or any applicable foreign law.

3.04. Other Adjustments.

- The amount of any benefit paid from the Plan to a participant or beneficiary under a Component Benefit shall be reduced by the amount of any excess payments previously made by the Plan to that participant or beneficiary under that Component Benefit, regardless of whether such excess payment was made by reason of an error of the Committee or the Trustee or by reason of false or misleading information furnished by the participant or beneficiary or any other person. Such reduction shall continue until the entire amount of any such excess payments has been recovered.

3.05. Payment to Participant or Beneficiary.

- (a) **Except as otherwise provided in paragraph (b), below, benefit payments under a Component Benefit shall be made to the participant in the Component Benefit or his beneficiary, if any.**
- (b) **To the extent permitted under a Component Benefit, payments may be made to a third party to whom a participant or beneficiary has made a valid assignment of his right to receive such payments. In addition, if the Committee determines that a participant or beneficiary is not competent, the Committee may authorize the Plan to make benefit payments to the court-appointed legal guardian of the participant or beneficiary, to an individual who has become the legal guardian of the participant or beneficiary by operation of state law, or to another individual whom the Committee determines to be entitled to receive such payments on behalf of the participant or beneficiary.**
- (c) **If a payment of benefits is made under a Component Benefits thereunder to a third party whom the Committee has determined to be entitled to receive such payment on behalf of a participant or beneficiary, the Plan, the Component Benefit and the Committee shall be relieved, to the fullest extent permitted by law, of any obligation to make a duplicate payment to or on behalf of such participant or beneficiary.**

Plan for Bargained Retired Group Ins.

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August 8, 1994

SECTION 4. ADMINISTRATION

4.01. Administrative Committee.

The Committee shall be the "plan administrator" with respect to the Plan for purposes of the Employee Retirement Income Security Act of 1974. The Committee shall be responsible for administering the Plan, and except as otherwise provided by a Component Benefit summary plan description, the Committee shall also administer each Component Benefit.

4.02. Named Fiduciary.

The Committee shall be the "named fiduciary" with respect to the Plan for purposes of the Employee Retirement Income Security Act of 1974. Except as otherwise provided in a Component Benefit, the Committee shall be the "named fiduciary" with respect to the Component Benefits for purposes of the Employee Retirement Income Security Act of 1974.

4.03. Powers and Duties of the Committee.

The Committee shall have discretionary authority to determine eligibility for benefits, to construe the terms of the Plan and the Component Benefits, and to decide any and all matters arising under the Plan and the Component Benefits, including without limitation the right to remedy possible ambiguities, inconsistencies, or omissions by general rule or particular decision, provided that all such interpretations and decisions shall be applied in a uniform and nondiscriminatory manner to all participants and beneficiaries who are similarly situated. In addition to such authority and any implied powers and duties that may be needed to carry out the provisions of this instrument, the Committee shall have the following specific powers and duties with respect to the Plan, and with respect to any Component Benefit (or portion thereof) that the Committee administers:

- (a) To make and enforce such rules and regulations as it shall deem necessary or proper for the efficient administration of the Plan and the Component Benefits;
- (b) To authorize disbursements from the Plan and the Component Benefits, provided that any instructions of the Committee authorizing disbursements from the Plan and the Component Benefits shall be in writing and signed by a member of the Committee or a delegate that has been given such authority; and
- (c) To employ one or more persons to render advice with respect to any of its responsibilities under the Plan or any Component Benefit(s).

4.04. Delegations of Authority By the Committee.

The Committee may, in its discretion, delegate to any other person or persons authority to act on behalf of the Committee, including but not limited to the authority to make any determination or to sign checks, warrants, or other instruments incidental to the operation of the Plan or any Component Benefit(s) (or portion thereof) that the Committee administers, or to the making of any payment specified therein.

4.05. Employment of Assistants.

The Committee and the Company are authorized to employ counsel and to employ persons to provide such actuarial, clerical, or other services as they may require in carrying out their duties under the Plan or any Component Benefit(s) provision.

4.06. Administration of the Trust.

Subject to the provisions of the Trust Agreement, the Trustee shall have responsibility for the management and control of the assets of the Plan that are held in the Trust. At the direction of the Committee, or any person to whom the Committee has delegated such authority pursuant to Section 4.04 hereof, the Trustee shall make payments from the Trust in order to pay benefits provided to participants and beneficiaries under a Component Benefit and in order to pay the administrative expenses of the Plan or any Component Benefit. The Committee may appoint or remove the Trustee, as provided in the Trust Agreement.

4.07. Processing of Claims.

The Committee shall adopt such rules for processing claims under the Plan and the Component Benefits as it deems advisable or as may be required by the Employee Retirement Income Security Act of 1974.

4.08. Claims Review Procedure.

- (a) Any participant or beneficiary whose claim for benefits under the Plan is denied shall be provided with a written explanation setting forth the specific reasons for the denial, a reference to the specific provision(s) of the Plan on which the denial is based, a description of any additional material or information necessary to perfect the claim, and an explanation of the Plan's claim review procedure.
- (b) The participant, his legal representative, or his beneficiary may request that the Committee reconsider the denial, by filing with the Committee a written request for reconsideration within 60 days of the receipt of written notice of the denial. In pursuing such a request, the claimant may review pertinent documents and may submit issues and comments in writing. The Committee shall make its decision on reconsideration within 60 days of receipt of the request for reconsideration, unless special circumstances require an extension of time for processing, in which case a decision shall

be rendered as soon as possible, but not later than 120 days after receipt of the request for reconsideration. If such an extension of time is required, the Committee shall furnish written notice of the extension of time to the claimant before the end of the original 60 day period. The decision on reconsideration shall be made in writing, shall be written in a manner calculated to be understood by the claimant, and shall include specific references to the provisions of the Plan on which the decision is based. If the decision on reconsideration is not furnished within the time specified above; the claim shall be deemed denied on reconsideration. All interpretations, determinations, and decisions of the Committee in respect of any claim shall be final and binding for all purposes and upon all interested persons, their heirs, and their personal representatives.

SECTION 5. FUNDING

5.01. Plan is a Single Plan.

The Plan and all of the Component Benefits shall be a single plan for purposes of the Employee Retirement Income Security Act of 1974. All of the assets of the Plan that are held in the Trust shall be available to provide benefits under any or all of the Component Benefits that together make up the Plan. The Employer's contributions to the Trust under a Component Benefit shall be available not only for the provision of benefits and the payment of any administrative expenses under that Component Benefit, but also to provide benefits under the other Component Benefit(s) that make up the Plan and to pay administrative expenses under the Plan and under the other Component Benefit(s).

Notwithstanding the foregoing, participants and beneficiaries enrolled in a health maintenance organization (HMO) shall look solely to the HMO for provision of health care services and payment of any claim relating to such services. If a Component Benefit is provided through an insurance contract with an insurance company, participants and beneficiaries shall look solely to such insurance company for the provision of such Component Benefit.

5.02. Contributions to the Trust.

- (a) The Employers shall contribute to the Trust from time to time an amount sufficient (after taking into account the assets of the Trust, contributions by participants and beneficiaries and contributions to the other funding arrangements provided for herein) to provide for benefits that participants and beneficiaries are anticipated to be entitled to receive under the Component Benefit(s) during the Year. In addition, the Employers, in their sole discretion, may provide benefits for participants and beneficiaries by paying contributions to one or more of the following: an insurance company as premium for an insurance contract or an HMO pursuant to an agreement with such HMO.
- (b) Participants and beneficiaries shall make such contributions to the Trust as are specified by the summary plan description for the applicable Component Benefit and by any elections that participants and beneficiaries make in accordance with the summary plan description for the applicable Component Benefit.
- (c) The reasonable expenses incident to the administration and operation of each Component Benefit, including the compensation of the Trustee, attorneys, advisors, actuaries, fiduciaries, and such other persons providing technical and clerical assistance as may be required, shall be paid out of the Trust unless the Company notifies the Committee that the Company or the Employers have paid or will pay such expenses.
- (d) If any Employer makes a contribution to the Trust by a mistake of fact, the Trustee shall return such contribution to that Employer within one year after the payment of the contribution.

- (e) **The assets of the Plan shall not include any of the general assets of the Employer that have not been contributed to the Trust, an insurance company, or an HMO.**