Rio Tinto

Please review, sign and return this document to the following address:
HRSS_.USA@riotinto.com

US Leave of Absence Employee Obligations

By signing this page, I acknowledge that I have read, understand and agree to the following requirements:

- ✓ I agree to provide 30 days advance notice when the need for leave is foreseeable.
- ✓ I understand and acknowledge that it is my responsibility to notify my supervisor of my status every two weeks during an extended leave.
- ✓ I understand and acknowledge that it is my responsibility to notify my supervisor and MetLife for every instance I am off for an approved intermittent leave in accordance with the call off procedures as they may exist from time to time. If you are not aware of the call off procedures, please consult with your supervisor.
- ✓ I understand and acknowledge that I may be required to provide recertification of a medical condition every 6 months, in accordance with the FMLA statute. Recertification may be required earlier in the event of a change in circumstances regarding your FMLA leave. I understand that if I fail to timely submit recertifications, my FMLA leave may be denied.
- ✓ I understand and acknowledge that FMLA and Salary Continuance (salaried) or Weekly Accident & Sickness (RTK represented) run concurrently. Both additional benefits only apply when it is a personal medical condition.
- ✓ I have reviewed and understand the document entitled "Your Rights & Obligations Under The Family Medical Leave Act" contained in this packet and agree to comply with its requirements.
- ✓ I understand and agree that I will be required to reimburse the Company for my share of health insurance contributions paid on my behalf during my FMLA leave.
- ✓ I hereby authorize Rio Tinto to deduct from my pay checks upon my return from leave, all benefit premium arrears in equal amounts over a maximum of 12 pay periods with a minimum deduction of $100 per pay period. I understand that I must contact Rio Tinto HR if I require an exception to the repayment schedule. If I do not return this document with my signature one week prior to my return from leave, I understand and acknowledge that the premiums I owe will be deducted in the maximum amount allowed by law beginning from my first pay check issued following my return to work until paid in full.
- ✓ I understand and agree that, if I fail to return to work following my approved FMLA leave as anticipated, the employer may require a medical recertification of my own or my family member's serious health condition in order to extend the FMLA leave, subject to eligibility and availability.
- ✓ I hereby authorize that if I do not provide the recertification within 30 days of the end of my approved leave or I do not return to work for reasons unrelated to my FMLA approved condition, the company is entitled to repayment of 100% of all health benefit premiums it paid on my behalf during my FMLA leave. I further authorize that such premiums may be recovered through deductions from any sums owed to me by the Company in accordance with applicable Federal or State law.
- ✓ I understand & acknowledge that if I fail to return to work at the end of my approved leave, I may be subject to discipline up to and including termination.
- ✓ I understand & acknowledge that if I engage in other employment while I am on an approved leave, I will be discharged unless the Company has pre-approved my request.

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Employees Signature – Payroll Number Date