SOUTHERN TIER BUILDING TRADES BENEFIT PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Of the Provisions of the Plan in Effect on May 1, 2022

TABLE OF CONTENTS

SECTION 1
INTRODUCTION AND IMPORTANT NOTICES
Introduction

The Southern Tier Building Trades Benefit Plan (the "Plan") is maintained pursuant to collective bargaining agreements between various unions and the Southern Tier Builders Association (the "Association"). The Plan has been in effect since 1956.

This booklet is the Plan Document and is also intended to operate as your Summary Plan Description. We invite you to carefully review these Plan provisions. This booklet explains the benefits available to you, your spouse, and your children through the Plan. This Plan helps to provide financial security for you and your spouse when you are faced with large health care premium expenses. We hope this booklet will serve not only as a guide but also as evidence of our concern for the welfare of you and your spouse.

The Trustees intend to continue the Plan indefinitely. However, they reserve the right to amend the Plan at any time and will notify you within the timeframe required under the law of any Plan amendment that would reduce any benefit. The Trustees also reserve the right to terminate the Plan at any time provided that you have been given at least 60 days advance notice of their intention to do so. Should the Plan be terminated for any reason, the assets of the Plan, if any, will continue to be used to provide benefits for medical care Covered Expenses received before the date of the termination, in the order received, until such time as the assets, if any, are exhausted.

The Plan is administered by the Joint Board of Trustees of the Southern Tier Building Trades Benefit Plan. The Joint Board of Trustees normally consists of one trustee appointed by each union participating in the Plan (or by the unions representing employees in the same trade) and an equal number of trustees appointed by the Association. You can request the names of the current Trustees from the Plan Office at 202 W. Fourth Street, Jamestown, NY 14701 (Telephone No. (716) 664-4391) during regular business hours. Any questions other concerning the Plan should also be directed to the Plan Office.

Notice of Grandfathered Plan Status

The Joint Board of Trustees believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, treatment for substance abuse or a mental condition. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the Plan Office at 202 W. Fourth Street, Jamestown, NY 14701 (Telephone No. (716) 664-4391). You may also contact the Employee Benefits Security Administration, U.S.

Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Notice of Right to Waive Participation in Reimbursement Account Coverage

A person eligible to have his medical expenses paid or reimbursed from a Reimbursement Account under the Plan is generally ineligible for a premium tax credit for health insurance obtained through a federal or state operated exchange, even if he does not have Plan Coverage. (See Section 4 (**Plan Coverage**) and Section 8 (**Reimbursement Accounts**)).

Therefore, an Employee (as defined in Section 3 (**Definitions**)) or former Employee eligible to have medical expenses paid or reimbursed from his Reimbursement Account may permanently waive Reimbursement Account coverage (and future Reimbursement Account payments and reimbursements) by completing and filing with the Plan Office a waiver form provided by the Plan Office. A participation waiver form filed by an Employee or former Employee will be effective and will apply to any and all medical expenses incurred for the Employee or former Employee, his Spouse or any of his Children (as defined in Section 3 (**Definitions**)) on and after the date it is filed.

A Spouse or a Child over age 18 eligible to have his medical expenses paid or reimbursed from his Reimbursement Account may permanently waive Reimbursement Account coverage (and future Reimbursement Account payments and reimbursements for his own medical expenses) by completing and filing with the Plan Office a waiver form provided by the Plan Office. A participation waiver form filed by a Spouse or Child will be effective (and will apply to his own medical expenses incurred) on and after the date it is filed.

SECTION 2
GENERAL PLAN INFORMATION

Plan Name	Southern Tier Building Trades Benefit Plan
Plan Number	501
Plan Type	Welfare Benefit Plan
Plan Year	Begins on May 1 and ends on April 30
Participating Unions/Plan Sponsors	Local No. 112, Sheet Metal Workers International Association Locals No. 621, Laborers International Union of North America Locals No. 264 and 449, International Brotherhood of Teamsters
Employer Organization/Plan Sponsor	Southern Tier Builders Association 65 East Main Street Falconer, New York 14733 (716) 665-4026 Upon written request, participants and beneficiaries may receive information as to whether a particular employer contributes to the Plan.
Tax Id Number	16-0810677
Plan Administrator	Joint Board of Trustees of the Southern Tier Building Trades Benefit Plan
Plan Agent for Service of Legal Process	Joint Board of Trustees of the Southern Tier Building Trades Benefit Plan 202 W. Fourth Street Jamestown, NY 14701 (716) 664-4391
Funding	Employers pay contributions to the Plan, based on a fixed amount per hour worked by employees. An employee may be required to pay for Plan Coverage if employers do not report and pay the minimum number of employee hours required for coverage. In addition, employees, spouses and dependents who elect COBRA Coverage are required to pay for coverage. All contributions and payments received are held by the Trustees in a trust and used (together with earnings) to pay Plan benefits and the cost of administering the Plan.

SECTION 3
GENERAL DEFINITIONS

Throughout the SPD, the following terms have the meaning indicated below, unless the context indicates otherwise.

Administrative or Supervisory Employee means an employee of an Employer whose duties do not include, and who does not perform, any work for an Employer described as bargaining unit work in any Collective Bargaining Agreement, or in any other collective bargaining agreement that covers persons working in the building trades. The Board has sole discretion to determine whether a collective bargaining agreement covers persons working in the building trades, and its decision is binding on all Employers and their employees.

Board means the Board of Trustees of the Plan.

Child means: (i) a Participant's natural or adopted son or daughter; (ii) a Participant's stepson or stepdaughter; (iii), a person placed with a Participant for adoption; or (iv) any other person who has a relationship with a Participant which requires the Plan to make coverage available to that person under federal law. The Board reserves the right to require proof that a person is a Participant's Child.

COBRA Coverage means continuation coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985. (See Section 11 (**Your Rights**) for a discussion of **COBRA Coverage**)

Collective Bargaining Agreement means a written agreement between a Union and an Employer requiring the Employer to make Contributions to the Plan on behalf of, and for all hours worked by, all Employees represented by the Union and covered by the agreement, at a Contribution Rate at least equal to the Minimum Contribution Rate. However, the Board has the discretion to classify a unit of Employees as "production employees." If it does, the Collective Bargaining Agreement covering those Employees may limit the number of Hours for which their Employer must make Contributions to the Plan to 40 hours per week per Employee.

Continued Eligibility Hour Bank means the bookkeeping account maintained by the Plan to track the number of Credited Hours a Participant has available to satisfy the Minimum Hour Requirement for Continued Eligibility, in accordance with Section 4 (**Plan Coverage**).

Contribution Rate means the hourly rate at which Contributions are required to be made by an Employer.

Contributions mean the contributions an Employer is required to pay to the Plan.

Covered Expense means an expense for a medical service, treatment, technology, procedure, care, drug, appliance, equipment, device, supply or other item that qualifies for payment by the Plan in accordance with the provisions, rules and limits in Section 5 (**Health Benefits**).

Credit Hour means an Hour credited to an Employee's Initial Eligibility Hour Bank or Continued Eligibility Hour Bank, in accordance with the provisions and rules in Section 4 (**Plan Coverage**).

Eligible Child means

- a Participant's Child under age 26; or

- a Participant's unmarried Child who has attained age 26 and: (i) is incapable of self-sustaining employment because of a mental or physical condition; (ii) became incapable of self-sustaining employment while he had Plan Coverage and was under age 26; and (iii) is dependent on the Participant for health care, financial support and maintenance. The Board reserves the right to require proof that a Child is incapable of self-sustaining employment because of a mental or physical condition and is dependent on the Participant for health care, financial support and maintenance.

For purposes of applying any Plan benefit limit or other Plan provision, a person will be treated as the Eligible Child of only one Participant (i.e., any benefit payable under the Plan will not be greater than the benefit payable if he were the Eligible Child of only one Participant.)

Eligible Former Employee means a person who: (i) is no longer an Employee; (ii) is not employed in any capacity; (iii) is not self-employed; (iv) had Plan Coverage immediately before he stopped being an Employee; and (v) immediately before he stopped being an Employee was either:

- an employee covered by and working under a Collective Bargaining Agreement between an Employer and a Union (provided, however, that he will no longer be an Eligible Former Employee on the date that Union is no longer a party to a Collective Bargaining Agreement);

- an employee of a Union (provided, however, that he will no longer be an Eligible Former Employee on the earlier of: (i) the date the Union stops making Contributions for all hours worked by all of its employees at a Contribution Rate at least equal to the Minimum Contribution Rate; or (ii) the date that Union is no longer a party to a Collective Bargaining Agreement);

- an employee of a district council to which a Union belonged, or a national or international union affiliated with a Union (provided, however, that he will no longer be an Eligible Former Employee on the earlier of: (i) the date the district council, national union or international union, stops making Contributions for all hours worked by all of its employees assigned to perform services solely for the Union at a Contribution Rate at least equal to the Minimum Contribution Rate; or (ii) the date that Union is no longer a party to a Collective Bargaining Agreement);

- an Administrative or Supervisory Employee of an Employer (provided, however, that he will no longer be an Eligible Former Employee on the earlier of: (i) the date the Employer stops making Contributions for all hours worked by all of its similarly situated Administrative or Supervisory Employees at a Contribution Rate at least equal to the Minimum Contribution Rate; or (ii) the date that Employer is no longer a party to a Collective Bargaining Agreement);

- an Administrative or Supervisory Employee of the Association (provided, however, that he will no longer be an Eligible Former Employee on the date the Association

stops making Contributions for all hours worked by all of its similarly situated Administrative or Supervisory Employees at a Contribution Rate at least equal to the Minimum Contribution Rate);

- an employee of the Upstate New York Laborers' Educational and Training Fund (or its legal successor) who performed services for members of a Union (provided, however, that he will no longer be an Eligible Former Employee on the earlier of: (i) the date the New York Laborers' Educational and Training Fund (or its legal successor) stops making Contributions for all hours worked by all of its Employees who perform services for members of a Union at a Contribution Rate at least equal to the Minimum Contribution Rate; or (ii) the date that Union is no longer a party to a Collective Bargaining Agreement); or

- an employee of the Plan.

Emergency Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in the Emergency Medical Treatment and Active Labor Act ("EMTALA"), including: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

Emergency Services mean with respect to an Emergency Condition, a medical screening examination (as required under EMTALA or as would be required under EMTALA if it applied to an Independent Freestanding Emergency Department) which is within the capability of the emergency department of a Hospital (or Independent Freestanding Emergency Department), including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital (or Independent Freestanding Emergency Department) and such further medical examination and treatment as are required to stabilize the patient, regardless of the department of the Hospital in which further examination or treatment is furnished.

"Emergency Services" also include certain post-stabilization services, unless the following conditions are met:

(1) The attending emergency Physician or treating Provider has determined that you are able to travel using non-medical transportation or non-emergency medical transportation to an available Network Provider or Facility located within a reasonable travel distance, taking into account your medical condition and any other relevant factor;

(2) If the Provider is a non-Network Provider, (a) the Provider gives you notice that the services rendered will be performed by an non-Network Provider and you consent to waive your rights under the surprise bill requirements, and (b) you or your authorized representative are in a condition to provide informed, voluntary consent; and

(3) The Provider satisfies any additional applicable laws and requirements including, without limitation, those provided in guidance issued by the Department of Health and Human

Services.

Employee means:

- an employee covered by and working under a Collective Bargaining Agreement which requires the Employer to make Contributions on his behalf at a Contribution Rate at least equal to the Minimum Contribution Rate;

- an employee of a Union that makes contributions on his behalf for all of his hours worked at a Contribution Rate at least equal to the Minimum Contribution Rate (provided (i) he is actually performing services for the Union, and (ii) the Union makes such Contributions for all hours worked by all of its employees);

- an employee of a district council to which a Union belongs, or an employee of a national or international union affiliated with a Union, that makes contributions on his behalf for all of his hours worked at a Contribution Rate at least equal to the Minimum Contribution Rate (provided (i) he is actually performing services for the district council, or national or international union, and (ii) the district council, national union or international union makes such Contributions for all hours worked by all of its employees assigned to perform services solely for the Union);

- an Administrative or Supervisory Employee of an Employer that makes contributions on his behalf for all of his hours worked at a Contribution Rate at least equal to the Minimum Contribution Rate (provided (i) he is actually performing services for the Employer, (ii) the Employer makes such Contributions for all hours worked by all of its similarly situated Administrative and Supervisory Employees, and (iii) the Employer is a party to a Collective Bargaining Agreement);

- an Administrative or Supervisory Employee of the Association for whom the Association makes contributions for all of his hours worked at a Contribution Rate at least equal to the Minimum Contribution Rate (provided (i) he is actually performing services for the Association, and (ii) the Association makes such Contributions for all hours worked by all of its similarly situated Administrative and Supervisory Employees);

- an employee of the Upstate New York Laborers' Educational and Training Fund who, in his capacity as such employee, performs services for members of a Union and for whom the Upstate New York Laborers' Educational and Training Fund (or its legal successor) makes Contributions for all of his hours worked at a Contribution Rate at least equal to the Minimum Contribution Rate (provided the Upstate New York Laborers' Educational and Training Fund makes such Contributions for all hours worked by all of its employees who perform services for members of a Union); and

- an employee of the Plan.

Employer means:

- an Employer that is a party to a Collective Bargaining Agreement;
- a Union;
- a district council to which a Union belongs, or a national or international union affiliated with a Union;
- the Association;
- the Upstate New York Laborers' Educational and Training Fund; and
- the Plan.

Hospital means an institution which is primarily engaged in providing persons on an inpatient basis, by or under the supervision of Physicians, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and which: (i) is accredited by the Joint Commission on Accreditation of Hospitals, and is licensed or approved by the State or local licensing agency as meeting the standards established for such licensing; (ii) maintains on its premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by, or under the supervision of, a staff of duly qualified Physicians; (iii) continuously provides on its premises 24 hour-a-day nursing service by, or under the supervision of, registered graduate nurses; (iv) operates on its premises continuously organized facilities owned by the Hospital) for operative surgery; and (v) is qualified to participate in, and is eligible to receive payments under the provisions of, Medicare.

An ambulatory surgical center is also considered a Hospital if it: (i) is established, licensed, equipped and operated in accordance with the applicable laws of the jurisdiction in which it is located primarily to perform surgical procedures on an outpatient basis; (ii) is operated under the supervision of a staff of Physicians and provides the full-time services of at least one registered graduate nurse; (iii) maintains medical records for each patient; (iv) does not provide its own place for patients to stay overnight; and (v) is not operated by one or more doctors solely for their own patients.

Hour means an hour worked by an Employee for which an Employer is obligated to make a Contribution to the Plan.

Independent Freestanding Emergency Department means a health care facility that provides Emergency Services and is geographically separate and distinct and licensed separately from a Hospital under applicable state law.

Initial Eligibility Hour Bank means the bookkeeping account maintained by the Plan to track the number of Credited Hours an Employee has available to satisfy the Minimum Hour Requirement for Initial Eligibility, in accordance with Section 4 (**Plan Coverage**).

Minimum Contribution Rate means the minimum hourly contribution rate determined by the Board. As of May 1, 2017, the Minimum Contribution Rate is $5.00 per Hour. However, the Minimum Contribution Rate may be changed from time to time by action of the Board and, subject to the provisions and rules in Section 4 (**Plan Coverage**), the Plan may accept Contributions for Hours worked by an Employee under a Collective Bargaining Agreement that provides for an Employer to make Contributions at a rate higher than the Minimum Contribution Rate.

Minimum Hour Requirement for Continued Eligibility means the minimum number of Credit Hours a Participant must have for his Plan Coverage to continue for a calendar month following the four calendar months of Plan Coverage provided after he satisfied the Minimum Hour Requirement for Initial Eligibility, in accordance with the provisions and rules in Section 4 (**Plan Coverage**).

Minimum Hour Requirement for Initial Eligibility means the minimum number of Credit Hours a Participant must have for his Plan Coverage to begin, or for his Plan Coverage to resume after it has ended, in accordance with the provisions and rules in Section 2 (**Plan Coverage**).

Network Provider is a provider that has an agreement pertaining to payment of Covered Expenses.

If you get health care from a non-Network Provider because the Plan or the Plan Office inaccurately told you (either through its website, provider directory, referral, or a phone call) that the non-Network Provider was a Network Provider, or you were not provided with written notice within one business day of your phone request of the network status of a Provider, then you are only required to pay the applicable in-Network Copayment or Coinsurance for that health care, and your cost sharing (i.e., your Copayment or Coinsurance) will count toward your annual out-of-pocket maximum.

A list of the Network Providers located in Western New York is available without charge at the Plan Office, at www.novahealthcare.com, or you may call 1-800-999-5703. A list of the Network Providers located outside Western New York is also available without charge at the Plan Office, at www.firsthealth.com, or you may call 1-800-226-5116.

Participant means an Employee or Eligible Former Employee who has Plan Coverage or is entitled to reimbursement of medical expenses from his Reimbursement Account.

Plan Coverage means coverage for the health, life, accidental death and dismemberment benefits described in Section 5 (**Health Benefits**) and Section 7 (**Life and Accidental Death and Dismemberment Benefits**). As used herein, Plan Coverage does not mean COBRA Coverage or a Participant who is entitled only to reimbursement of medical expenses from his Reimbursement Account. (See Section 11 (**Your Rights**) for a discussion of **COBRA Coverage** and Section 8 (**Reimbursement Accounts**)) Only Employees, Eligible Former Employees satisfying the requirements in Section 4 (and their Spouses and Eligible Children) are eligible for Plan Coverage. A person not eligible for Plan Coverage may still be entitled to COBRA Coverage or reimbursement of medical expenses from his Reimbursement Account in accordance with the provisions, rules and limits in Section 8.

Physician means a licensed medical physician; M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who is legally qualified to practice medicine in accordance with all applicable laws. The services performed by a Physician are subject to any limitations imposed by law on the scope of practice.

Plan Year means the 12 consecutive month period ending each April 30th.

Provider means an individual who is operating within the scope of his or her license to provide Medically Necessary services as set forth in Section 5 of the Plan.

Reimbursement Account means an individual account established for reimbursement of medical expenses, as described in Section 8 (**Reimbursement Accounts**).

Self-Pay or **Self-Payment** means direct payment for Plan Coverage following the first four months of Plan Coverage provided after satisfying the Minimum Hour Requirement for Initial Eligibility, in accordance with the provisions, rules and limits in Section 4 (**Plan Coverage**).

Spouse means a person to whom a Participant is legally married and who is treated as the Participant's spouse under federal or state law. For purposes of applying any Plan benefit limit or other Plan provision, if two Participants are legally married to each other any benefit payable under the Plan with respect to either Participant will not be greater than the benefit payable if that Participant were not married to another Participant.

Union means a labor organization that participates in the Plan with the consent of the Board and is a party to a Collective Bargaining Agreement or, after the expiration a Collective Bargaining Agreement, is attempting to negotiate, or has taken labor action in an effort to reach, a successor Collective Bargaining Agreement.

SECTION 4
PLAN COVERAGE

Employee and Former Employee Eligibility for Plan Coverage. Employees and Eligible Former Employees are eligible for Plan Coverage during a calendar month only if they have timely and properly filed with the Plan the necessary application and any other forms required by the Board for Plan Coverage, and either:

- satisfy the Minimum Hour Requirement for Initial Eligibility or the Minimum Hour Requirement for Continued Eligibility;
- are eligible for and timely make Self-Payments; or
- are eligible for and timely elect COBRA Coverage.

Minimum Hour Requirement for Initial Eligibility, Minimum Hour Requirement for Continued Eligibility, and Self-Payment rules are discussed in this Section 4. Also discussed in this Section are the general rules regarding crediting, debiting, and adjustment of Credit Hours, and the circumstances under which a Participant forfeits his Credit Hours and loses Plan Coverage. (See Section 11 (**Your Rights**) for a discussion of **COBRA Coverage**)

Minimum Hour Requirement for Initial Eligibility. An Employee must satisfy the Minimum Hour Requirement for Initial Eligibility for his Plan Coverage to begin for the first time and for his Plan

Coverage to resume after it has ended. Subject to the other rules in this Section 4, when an Employee satisfies the Minimum Hour Requirement for Initial Eligibility, he is eligible for Plan Coverage for four consecutive calendar months (without having to satisfy the Minimum Hour Requirement for Continued Eligibility), beginning with the calendar month following the calendar month in which he satisfies the Minimum Hour Requirement for Initial Eligibility.

The Minimum Hour Requirement for Initial Eligibility is 600 Credit Hours, but may be changed from time to time by the Board. In addition to the general rules below for crediting, debiting and adjusting Credit Hours, the following rules apply to Credit Hours used to satisfy the Minimum Hour Requirement for Initial Eligibility.

- Only Hours credited in a calendar month after June 2004 and in which an Employee does not have Plan Coverage are credited to his Initial Eligibility Hour Bank.

- Whether an Employee satisfies the Minimum Hour Requirement for Initial Eligibility on any date is based on the number of his Credit Hours in his Initial Eligibility Hour Bank as of the previous month.

- If the Contribution Rate for Hours is greater than the Minimum Contribution Rate then, before those Hours are credited to his Initial Eligibility Hour Bank, they are increased based on the following formula:

  Hours with greater Rate X <u>Greater Contribution Rate</u> Contribution Minimum Contribution Rate

- If, as of the end of the month an Employee satisfies the Minimum Hour Requirement for Initial Eligibility, and the number of Credit Hours in his Initial Eligibility Hour Bank is greater than the number needed to satisfy the Minimum Hour Requirement for Initial Eligibility, the excess Credit Hours are converted to a dollar amount and credited to his Reimbursement Account; <u>provided, however, that no amount is credited to a Participant's Reimbursement Account unless he is enrolled in Plan Coverage (as defined in Section 3 (**Definitions**)) at the time it is credited</u>. The amount credited to his Reimbursement Account equals the number of such excess Credit Hours (after the increase described above, if applicable) multiplied by the Minimum Contribution Rate.

- An Employee cannot Self-Pay to make up the difference between the Minimum Hour Requirement for Initial Eligibility and the number of Credit Hours in his Initial Eligibility Hour Bank.

The rules above also apply to hours worked in the jurisdiction of another health and welfare plan if the Plan receives employer contributions for those hours pursuant to a reciprocal agreement, but see **General Rules for Crediting, Debiting and Adjusting Hours** below for how those hours are adjusted when the employer contribution rate for the hours is less than the Minimum Contribution Rate.

The following examples show how some of the rules above work. Note that if there is, or appears to be, any discrepancy between the rules above and the examples below, the rules control your right to

Plan Coverage. Also, all of the examples below assume that the Minimum Hour Requirement for Initial Eligibility is 600 Credit Hours and the Minimum Contribution Rate is $5.40 per Hour (the Minimum Contribution Rate as of July 1, 2019).

Example 1: An Employee does not have Plan Coverage in July 2019, but works 150 Hours in that month. His Employer reports the 150 Hours to the Plan, and contributes for the Hours at the rate $5.60 per Hour, by August 28, 2019. These Hours are increased to 155½ Hours (150 Hours x $5.60/$5.40 = 155½ Hours) and credited to his Initial Eligibility Hour Bank. If the Employer contributes for all of the Employee's Hours at this same rate, he will need only 578½ Hours to satisfy the Minimum Hour Requirement for Initial Eligibility ($5.60/$5.40 x 578½Hours = 600 Hours).

Example 2: Suppose the Employee in Example 1 had Credit Hours as of the end of June 2004. Those Hours would not count toward the Minimum Hour Requirement for Initial Eligibility. He must satisfy the Minimum Hour Requirement for Initial Eligibility with Hours credited after June 30, 2004.

Example 3: An Employee first begins working for a contributing Employer in July 2019. In November 2019, he has a total of 600 Credit Hours in his Initial Eligibility Hour Bank. The Employee has satisfied the Minimum Hour Requirement for Initial Eligibility. He is eligible for Plan Coverage beginning December 1, 2019. The first 150 Hours credited to the Employee for each month from December 2019 through March 2020 may be used to satisfy the Minimum Hour Requirement for Continued Eligibility beginning April 2020.

Example 4: Suppose the Employee in Example 3 had more than 600 Credit Hours in his Initial Eligibility Hour Bank in November 2019 (after the increase described above if the Contribution Rate is greater than the Minimum Contribution Rate). The excess Credit Hours will be converted to a dollar amount and credited to his Reimbursement Account if he is enrolled in Plan Coverage (as defined in Section 3 (**Definitions**)). The dollar amount will equal the number of excess Credit Hours multiplied by the Contribution Rate.

Minimum Hour Requirement for Continued Eligibility. An Employee must satisfy the Minimum Hour Requirement for Continued Eligibility in order for his Plan Coverage to continue following the four months of Plan Coverage provided after he satisfies the Minimum Hour Requirement for Initial Eligibility. Subject to the Self-Payment and other rules in this Section 4, for each calendar month that an Employee satisfies the Minimum Hour Requirement for Continued Eligibility, he is eligible for Plan Coverage that month. If an Employee does not satisfy the Minimum Hour Requirement for Plan Coverage for a calendar month he will not be eligible for Plan Coverage that month unless Self-Payment or COBRA Coverage applies.

The Minimum Hour Requirement for Continued Eligibility is 150 Credit Hours, but may be changed from time to time by action of the Board. In addition to the general rules below for crediting, debiting and adjusting Credit Hours, the following rules apply to the Credit Hours applied to satisfy the Minimum Hour Requirement for Continued Eligibility.

- Any Hours credited to an Employee as of June 30, 2004 were credited to his Continued Eligibility Hour Bank.

- All Hours credited in a calendar month after June 2004 and in which an Employee has Plan Coverage (including the four calendar months of Plan Coverage provided for

satisfying the Minimum Hour Requirement for Initial Eligibility) are credited to his Continued Eligibility Hour Bank.

- Whether an Employee satisfies the Minimum Hour Requirement for Continued Eligibility for any month is based on the number of his Credit Hours in his Continued Eligibility Hour Bank as of the previous month.

- Only the first 150 Hours worked by an Employee in a calendar month may be credited to a Participant's Continuing Eligibility Hour Bank. Any Hours in excess of 150 are converted to a dollar amount and credited to his Reimbursement Account at the time those Hours would have otherwise been credited to his Continuing Eligibility Hour Bank; provided, however, that no amount is credited to a Participant's Reimbursement Account unless he is enrolled in Plan Coverage (as defined in Section 3 (**Definitions**)) at the time it is credited. The amount credited to his Reimbursement Account equals the number of such Hours in excess of 150 multiplied by the Contribution Rate for those Hours. (For purposes of determining this excess, no Hours credited to an Employee prior to May 2000 are considered.)

- If the Contribution Rate for Hours credited to a Participant's Continued Eligibility Hour Bank is greater than the Minimum Contribution Rate, the excess amount is also credited to his Reimbursement Account at the time those Hours are credited; provided, however, that no amount is credited to a Participant's Reimbursement Account unless he is enrolled in Plan Coverage (as defined in Section 3 (**Definitions**)) at the time it is credited. The amount credited to his Reimbursement Account equals the number of those Credit Hours multiplied by the difference between: (i) the Contribution Rate; and (ii) the Minimum Contribution Rate.

- The most recent Hours credited to a Participant's Continued Eligibility Hour Bank are applied first to satisfy the Minimum Hour Requirement for Continued Eligibility.

- If the number of Credit Hours in his Continued Eligibility Hour Bank is less than the Credit Hours needed to satisfy the Minimum Hour Requirement for Continued Eligibility, then the Participant must Self-Pay to continue Plan Coverage. The Self-Payment must make up the difference between the Minimum Hour Requirement for Continued Eligibility and the number of his Credit Hours in his Continued Eligibility Hour Bank. The amount he must Self-Pay is based on the following formula:

Additional Credit Hours needed to satisfy Minimum Hour Requirement for Continued Eligibility	X	Minimum Contribution Rate in effect for the month the Participant Self-Pays for Plan Coverage

- If a Participant fails to make the Self-Payment described above for a calendar month by the due date for that Self-Payment, his Plan Coverage will end as of the last day of the previous calendar month.

See **Self-Payment** below for additional rules regarding Self-Payment.

The rules above also apply to hours worked in the jurisdiction of another health and welfare plan if the Plan receives employer contributions for those hours pursuant to a reciprocal agreement, but see **General Rules for Crediting, Debiting and Adjusting Hours** below for how those hours are adjusted when the employer contribution rate for the hours is less than the Minimum Contribution Rate.

The following examples show how some of the rules above work. Note that if there is, or appears to be, any discrepancy between the rules above and the examples below, the rules control your right to Plan Coverage. Also, all of the examples below assume that the Minimum Hour Requirement for Continued Eligibility is 150 Hours and the Minimum Contribution Rate is $5.40 per Hour (the Minimum Contribution Rate as of July 1, 2019).

Example 1: Because an Employee satisfied the Minimum Hour Requirement for Initial Eligibility, he has Plan Coverage from July through October 2019. He also works 150 Hours in September 2019. His Employer reports the 150 Hours to the Plan by October 28, 2019. Those Hours are credited to his Continuing Eligibility Hour Bank in October 2019, and he will have Plan Coverage in November 2019.

Example 2: Suppose the Employee in Example 1 above worked 160 Hours in September 2019, and the Contribution Rate for those Hours was $5.60. His Reimbursement Account would be credited with a total of $84 [$30 ($.20 x 150) plus $54 ($5.40 x 10 Hours)] if he is enrolled in Plan Coverage (as defined in Section 3 (**Definitions**)).

Example 3: Suppose the Employee in Example 1 above worked only 100 Hours in September 2019 but already had 300 Credit Hours in his Continuing Eligibility Hour Bank. The 100 Hours worked in September 2019 are added to his Continuing Eligibility Hour Bank, and 150 of the Credit Hours in his Continuing Eligibility Hour Bank may be applied to satisfy the Minimum Hour Requirement for Continued Eligibility for November 2019. In that case, he would have 250 Credit Hours remaining in his Continuing Eligibility Hour Bank.

Example 4: Suppose the Employee in Example 1 above worked only 100 Hours in September 2019 and had no other Credit Hours in his Continuing Eligibility Hour Bank. This Employee must Self-Pay $270 ($5.40 x 50 Hours = $270). If he does, he will have Plan Coverage in November 2019. If he does not, his Plan Coverage will end as of October 31, 2019 and, to be eligible for Plan Coverage again, he must be an Employee and again satisfy the Minimum Hour Requirement for Initial Eligibility. (See **Self- Payment** below for additional rules regarding Self-Pay, including the due date for Self- Payments.)

General Rules for Crediting, Debiting and Adjusting Hours. Hours are credited, debited and adjusted in accordance with the following rules.

- Subject to the rules below, Hours reported by an Employer to the Plan between the 1st and 28th day of a month are credited to the Employee's Initial or Continuing Eligibility Hour Bank as of the last day of the calendar month they are reported (i.e., the earliest the Hours can be used to satisfy the Minimum Hour Requirement for Initial or Continued Eligibility is the calendar month after they are reported).

- Subject to the rules below, Hours reported by an Employer between the 29th day and the end of a month are credited to the Employee's Initial or Continuing Eligibility Hour Bank as of the last day of the second calendar month after they are reported (i.e., the earliest these Hours can be used to satisfy the Minimum Hour Requirement for Initial or Continued Eligibility is the second calendar month after they are reported).

- Except for Hours credited when payment of contributions is verified by a plan with a reciprocal agreement with this Plan, no more than two months of Hours worked by an Employee are credited without payment of the Contributions for the Hours to the Plan. If the Plan does not receive Contributions for more than two months of Hours and the Employer later pays the Contributions for the Hours, then the Hours that were not credited because of this rule are credited as if they were first reported on the date the Contributions are received by the Plan.

- Subject to the rule above limiting credit for Hours without payment of Contributions to the Plan, if an Employer fails to submit a monthly report indicating the number of Hours worked by an Employee, then upon final verification of the Hours worked, satisfactory to the Board, the appropriate Hours for the month are treated as reported and are credited, but not before the earlier of: (i) the date one year after the date the Hours were worked; or (ii) exhaustion of all collection remedies, including completion of any legal action commenced at the discretion of the Board. If the final verification is made between the 1st and 28th day of a month, the Hours are credited as if they were reported by an Employer between the 1st and 28th day of that month, and if the final verification is made between the 29th day and the end of a month, the Hours are credited as if they were reported by an Employer between the 29th day and the end of that month.

- Notwithstanding the rule above limiting credit for Hours without payment of Contributions to the Plan, if the contributions or verification of payment of contributions is received from a plan with a reciprocal agreement with this Plan between the 1st and 28th day of a month, the Hours are credited as if they were reported by an Employer between the 1st and 28th day of that month, and if the contributions or verification of payment is received from the other plan between the 29th day and the end of a month, the Hours are credited as if they were reported by an Employer between the 29th day and the end of that month.

- As of the end of each month an Employee's Initial or Continuing Eligibility Hour Bank is reduced by Credit Hours actually applied for Plan Coverage that month, at the rate of 150 Credit Hours per month.

- Whenever the Minimum Contribution Rate changes, the number of Credit Hours in each Initial and Continuing Eligibility Hour Bank is adjusted by multiplying them by a fraction, (i) the numerator of which is the old Minimum Contribution Rate; and (ii) the denominator of which is the new Minimum Contribution Rate. This adjustment will be made as of first day of the second calendar month following the month in which the new Minimum Contribution Rate first applies.

Example: Suppose the Minimum Contribution Rate is increased as of July 1, 2019. The number of Hours in each Participant's Initial Eligibility Hour Bank and Continuing Eligibility Hour Bank will be reduced as of September 1, 2019, using the formula above.

- If the Plan receives employer contributions for hours worked by an employee in the jurisdiction of another plan that has a reciprocal agreement with this Plan then, for purposes of the rules in this Section 4, those hours will be treated as Hours worked for an Employer under a Collective Bargaining Agreement (as defined in Section 3 (**General Definitions**)), and the contributions will be treated as Contributions made to this Plan pursuant to a Collective Bargaining Agreement. However, if the employer contribution rate for those hours is less than the Minimum Contribution Rate then, before applying any of the other rules in this Section 4, the hours will first be reduced based on the following formula:

Hours with lesser Contribution Rate	X	Lesser Contribution Rate / Minimum Contribution Rate

Self Payment.

- A person can Self-Pay for Plan Coverage only to satisfy the Minimum Hour Requirement for Continued Eligibility (not to satisfy the Minimum Hour Requirement for Initial Eligibility). Furthermore, only a Participant who is, and continues to be, an Employee or an Eligible Former Employee is eligible for Plan Coverage through Self-Payment.

- A Participant can pay the full Self-Payment amount for Plan Coverage only for 12 consecutive months, unless he is retired under the terms of a qualified retirement plan sponsored by a Union participating in the Plan.

  Example: An Employee is eligible for Plan Coverage through Credit Hours in his Initial or Continuing Eligibility Hour Bank through the end of June 2019. For each month from July 2019 through and including June 2020, he pays the full Self-Payment amount to keep his Plan Coverage in effect. He is not retired under the terms of a qualified retirement plan sponsored by a Union participating in the Plan, and has no Credit Hours in his Continuing Eligibility Hour Bank as of the end of June 2020. After June 2020, he can no longer keep his Plan Coverage in effect by paying the full Self-Payment amount, so his Plan Coverage ends June 30, 2020. However, he, his Spouse and his Eligible Children may elect COBRA Coverage. (See Section 11 (**Your Rights**) for a discussion of **COBRA Coverage**).

- For a Participant who is an Eligible Former Employee, is eligible for Medicare Part D prescription drug coverage, and either has no Spouse or has a Spouse who is also eligible for Medicare Part D prescription drug coverage, the Self-Payment amount will be as determined by the Board from time to time. The Self-Payment amount due for a calendar month for any other Participant is the amount determined under the normal Self- Payment formula above. (See **Minimum Hour Requirement for Continued**

Eligibility)

- The Self-Payment amount for a calendar month is due in the Plan Office by the 15th day of that month.

Forfeiture of Credit Hours and Loss of Plan Coverage.

- If an Employee or Eligible Former Employee does not satisfy the Minimum Hour Requirement for Continued Eligibility for a calendar month and is not eligible to Self-Pay for that month, his Plan Coverage will end as of the last day of the previous calendar month. (See the Example under **Self-Payment** above) To be eligible for Plan Coverage again, he must be an Employee and again satisfy the Minimum Hour Requirement for Initial Eligibility.

- If an Employee or Eligible Former Employee is eligible to Self-Pay but fails to pay the appropriate Self-Payment amount for a calendar month by the due date for that Self-Payment, then: (i) his Plan Coverage will end as of the last day of the previous calendar month; and (ii) to be eligible for Plan Coverage again, he must be an Employee and again satisfy the Minimum Hour Requirement for Initial Eligibility.

- All of an Employee's Credit Hours are cancelled and permanently forfeited at the end of the calendar month in which he dies. Under no circumstances will his Spouse, Eligible Children or any other person be entitled to any consideration for the forfeited Credit Hours, including, but not limited to, future Plan Coverage or cash payment.

- Unless he is an Eligible Former Employee, all of an Employee's Credit Hours are cancelled and permanently forfeited, and his Plan Coverage ends, at the end of the calendar month immediately following the calendar month he is no longer an Employee. If, as of the date he is no longer an Employee, he is an Eligible Former Employee but later ceases to be an Eligible Former Employee (without becoming an Employee again), his Credit Hours are cancelled and permanently forfeited, and his Plan Coverage ends, at the end of the calendar month immediately following the calendar month he is no longer an Eligible Former Employee. Under no circumstances will he be entitled to any consideration for the forfeited Credit Hours, including, but not limited to, future Plan Coverage or cash payment. This provision does not affect an individual's right to COBRA Coverage.

The following examples show how some of the rules above work. (Note that if there is, or appears to be, any discrepancy between the rules above and the examples below, the rules control your right to Plan Coverage.)

Example 1: An Employee stops working for a contributing Employer and starts working for a non-contributing employer. His Plan coverage will terminate and all of his Credit Hours will be forfeited at the end of the calendar month following the calendar month in which he started working for a non-contributing employer.

Example 2: A Union stops participating in the Plan and its members start participating in a different health plan or the Union offers no health coverage for its members. Plan Coverage for all members

of the Union will terminate, and all their Credit Hours will be forfeited, at the end of the calendar month following the calendar month in which the Union stops participating in the Plan.

Example 3: An Employer contributes to the Plan for Union members under a Collective Bargaining Agreement, and also contributes for its Administrative and Supervisory Employees. When the Collective Bargaining Agreement expires, the Employer and the Union reach an impasse in negotiations for a new agreement. Plan Coverage for any Union member, Administrative or Supervisory Employee working for that Employer after the impasse will terminate, and all of his Credit Hours will be forfeited, at the end of the calendar month following the calendar month in which the impasse is reached.

Spouses and Eligible Children. Subject to COBRA Coverage requirements, a Participant's Spouse and Eligible Children are covered under the Plan during the period, and for so long as, the Participant has Plan Coverage and they qualify as his Spouse or Eligible Children; provided, however, that if the Participant dies while eligible for Plan Coverage, health coverage under the Plan for his surviving Spouse and Eligible Children will continue without regard to the Participant's Credit Hours at no cost to the Spouse and Eligible Children until the earlier of: (i) the date one year after the Participant's death; (ii) the date the Spouse or Eligible Child becomes eligible for other health coverage or Medicare benefits; (iii) in the case of a Participant's surviving Spouse, the date the surviving Spouse remarries; or (iv) in the case of an Eligible Child, the date he reaches age 26.

Participants must report any family status change to the Plan Office as soon as possible to ensure proper coverage (e.g., marriage, divorce, birth, adoption or other event which affects the Participant's, Spouse's or Child's eligibility for coverage).

SECTION 5
HEALTH BENEFITS

General. The Plan pays only Covered Expenses incurred by a Participant for himself, his Spouse and his Eligible Children when he has Plan Coverage. Payment may be made directly to the Participant or to a health care provider. ***All payments for Covered Expenses are subject to all of the provisions, rules and limits in this Section 5, and the provisions and rules in Section 6 (Coordination of Benefits, Right of Recovery and Subrogation)***.

Reasonable and Customary Charge. The Plan's payment for a Covered Expense is based only on the Reasonable and Customary Charge for the Covered Expense. A Reasonable and Customary Charge is determined based on what other health care providers of the same professional standing in the same geographic area usually charge for the same or similar medical services or supplies provided to a person of the same sex and similar age for the same or a similar injury or illness.

Case Management. The Plan reserves the right to incorporate Case Management services into the Plan's benefit provisions. Case Management monitors patients who have suffered a catastrophic sickness or injury which may require long-term care and explores, discusses and recommends coverage for coordinated and/or alternate types of appropriate Medically Necessary care.

In certain cases, the case manager may recommend coverage of alternative care and/or treatment when Medically Necessary and cost effective at a Center of Excellence, a facility with proven expertise and success rates in the specific type of care and/or treatment needed. If the alternative

treatment plan is approved, the Plan may cover Medically Necessary expenses as stated in the alternative treatment plan, even if the Plan would not normally pay those expenses.

Deductible Amount. The Plan only pays Covered Expenses that exceed the Deductible Amount. The Deductible Amount is the amount of certain Covered Expenses incurred during a calendar year that the Participant, Spouse or Eligible Child must pay before he is entitled to payment or reimbursement by the Plan for the remainder of such Covered Expenses incurred during that calendar year. The Deductible Amount is separate from any Co-payment and any part of a Covered Expense in excess of the Reasonable and Customary Charge. The Deductible Amount can be satisfied only with expenses that would be covered under the Plan but for the Plan's Deductible Amount requirements. Co- payments and Co-insurance payments are not taken into account when determining whether any Deductible Amount has been satisfied.

- For Covered Expenses that are in-patient Hospital charges, there is a Deductible Amount of $200 for each Hospital stay at a network Hospital, and $500 for each Hospital stay at any other Hospital. A network Hospital is a Hospital under contract with a preferred provider organization (PPO) to provide inpatient and outpatient Hospital services for persons covered under the Plan**.** The network includes most Hospitals in the New York State Southern Tier area, and other Hospitals throughout the United States. A Participant can obtain a list of network Hospitals from the Plan Office. The Participant is responsible for paying the in-patient Hospital Deductible Amount plus any other Hospital expenses not covered by the Plan. However, the in-patient Hospital Deductible Amount is waived for: (i) inpatient Medicare recipients; and (ii) patients who are readmitted to a Hospital within 60 days of the last discharge.

- Except as noted below, for Covered Expenses that are not in-patient Hospital charges there is: (i) an individual annual Deductible Amount of $300 per Participant, $300 per Spouse and $300 per Eligible Child; and (ii) a family annual Deductible Amount of $600.

- No Deductible Amount applies to Covered Expenses for: chiropractic care; pre-natal an post-natal maternity care (other than diagnostic x-rays, laboratory tests and examinations); prescription drugs; immunizations; preventive health screenings (arranged by the Plan Office); routine physical examinations; smoking cessation benefits; surgery; or vision benefits.

- After the Participant, his Spouse or one of his Eligible Children satisfies the individual annual Deductible Amount requirement and the total family Deductible Amount is reached by the Participant and all of his family members, there is no additional Deductible Amount for the Participant, Spouse or any Eligible Child for the remainder of the calendar year.

Co-insurance Payment. The Plan does not pay the Co-insurance payment for a Covered Expense. A "Co-insurance payment" is the portion of certain Covered Expenses that a Participant, his Spouse or Eligible Child must pay, calculated as a percent (for example, 20%) of the allowed amount for the Covered Expense. The Participant, Spouse or Eligible Child pays the Co-insurance payment, plus any Deductible Amount and any amount in excess of the Reasonable and Customary Charge.

A 20% Co-insurance payment applies to Covered Expenses except Covered Expenses for: chiropractic care; Hospital room, board, services and supplies; pre-natal and post-natal maternity care (other than diagnostic x-rays, laboratory tests and examinations); prescription drugs purchased at a retail pharmacy participating in the prescription drug card program or through the mail-in prescription drug card program (see **Prescription Drugs** under **Special Rules and Limits** below); immunizations; preventive health screenings (arranged by the Plan Office); routine physical examinations; smoking cessation benefits; and surgery. A 90% Co-insurance payment applies to certain vision benefits (frames, prescribed glass lenses and prescribed contact lenses) above the Plan's allowance for these items (see **Vision Benefits** under **Special Rules and Limits** below).

Co-payment. The Plan does not pay the Co-payment for a Covered Expense. A "Co- payment" is the fixed dollar amount a Participant, his Spouse or Eligible Child must pay for certain Covered Expenses, usually at the time the Covered Expense is incurred. The amount can vary by the type of Covered Expense. A Co-payment is separate from any Deductible Amount and any part of a Covered Expense in excess of the Reasonable and Customary Charge. If the Participant, Spouse or Eligible Child has more than one visit, or the same visit, with multiple Co-payments on the same day, the Participant, Spouse or Eligible Child is responsible for each applicable Co-payment.

A Co-payment applies to prescription drugs purchased at a retail pharmacy participating in the prescription drug card program or through the mail-in prescription drug card program, and to chiropractic services.

Out-of-Pocket Maximum. The Out-of-Pocket Maximum is the amount of certain expenses a Participant, his Spouse or Eligible Child must incur during a calendar year before the Plan pays 100% of the remainder of certain Covered Expenses incurred during that calendar year.

When determining whether the Out-of-Pocket Maximum has been reached, the following are excluded: (i) Co-payments; (ii) Deductible Amounts for in-patient Hospital charges; Co-insurance for certain vision benefits (frames, prescribed glass lenses and prescribed contact lenses); (iv) any expense (or portion of an expense) that is not a Covered Expense, or is in excess of the Reasonable and Customary Charge or a benefit limit under the Plan (e.g., a dollar allowance or per visit limit); (v) balanced-billed charges; and (vi) any Self-Payment or COBRA coverage premium.

When determining what expenses the Plan will pay once the Out-of-Pocket Maximum has been reached, the following are excluded (i.e., not paid by the Plan): (i) Co-payments; (ii) the Deductible Amount for in-patient Hospital charges; (iii) Co-insurance for certain vision benefits (frames, prescribed glass lenses and prescribed contact lenses); (iv) Co- insurance payments for prescription drugs not purchased at a retail pharmacy participating in the prescription drug card program or through the mail-in prescription drug card program; and (v) any expense (or portion of an expense) that is not a Covered Expense, or is in excess of the Reasonable and Customary Charge or a benefit limit under the Plan (e.g., a dollar allowance amount or per visit limit).

- There is a $2,500 individual Out-of-Pocket Maximum Amount for each Participant, Spouse and Eligible Child. Once the total expenses (except those described above) incurred during a calendar year for that individual reach this $2,500 individual Out-of-Pocket Maximum, the Plan pays 100% of the Covered Expenses (except those described above) incurred for that individual during the rest of the calendar year.

- A $5,000 Out-of-Pocket Maximum Amount applies to each family if at least one family member has reached the $2,500 individual Out-of-Pocket Maximum Amount. Once the total expenses (except those described above) incurred during the calendar year for a Participant, his Spouse and/or his Eligible Children reach the $5,000 family Out-of-Pocket Maximum, and the total expenses (except those described above) incurred during the same calendar year for at least one of them reaches the $2,500 individual Out-of- Pocket Maximum Amount, the Plan pays 100% of the Covered Expenses (except those described above) incurred for any of them during the rest of the calendar year.

Covered Expenses. The Plan pays only Covered Expenses that are "Medically Necessary" for the diagnosis or treatment of an injury, illness or medical condition, or to improve the function of a malformed body member. To be considered Medically Necessary, a service, treatment, drug, supply, or other item must be: (i) provided, prescribed, ordered, recommended or approved by a licensed health care provider (unless stated otherwise in the Plan); (ii) appropriate for the diagnosis and treatment of the patient's symptoms, condition, illness or injury; (iii) consistent with generally accepted standards of professional medical practice in the United States; (iv) provided for the diagnosis, or the direct care and treatment, of the patient's condition, illness or injury; (v) primarily medical in nature, and not primarily for the convenience of the health service provider, the patient or his family; and (vi) the most appropriate level of service or supply that can safely be provided. The fact that a health care provider may provide, prescribe, order, recommend, or approve a service, treatment, drug, supply or other item does not, in itself, make the service Medically Necessary. Services, treatment, drugs or other items that are not Medically Necessary include, but are not limited to: (i) services or treatment provided over a longer period of time than necessary for effective diagnosis and treatment of the patient's illness or injury; and (ii) services, treatment, drugs or other items provided to a person because he failed to fully comply with the medical or dental regime established by a health care provider.

Subject to **Exclusions** and **Special Rules and Limits** below, expenses for the following services, treatment, drugs, supplies and items are Covered Expenses if they are Medically Necessary. They are also subject to a 20% Co-insurance payment and any other specific limits described below.

- Physician office visits for treating an illness or injury.
- Health care services provided by a Physician while the patient is confined in a Hospital.
- Anesthesia and its administration.
- Diagnostic x-rays, diagnostic laboratory tests, other diagnostic tests and examinations.
- X-ray, radium, radiation and chemotherapy treatment, including materials and the services of technicians.
- Blood transfusions and cost of blood not donated or replaced.
- A second opinion on the need for non-emergency inpatient surgery.
- Oxygen and other gases and their administration.
- Rental or purchase of certain durable medical equipment. For purposes of the Plan, durable medical equipment means necessary and reasonable equipment and supplies used to serve a specific medical and/or therapeutic purpose in the treatment of an

illness or injury appropriate for use in the patient's home which is: (i) able to withstand repeated use (i.e., the type of item that is designed for prolonged use and could normally be rented); (ii) primarily and customarily used to serve a medical purpose rather than for comfort or convenience; (iii) generally useful only to a person with the illness or injury; and (iv) prescribed by the Physician who is treating the patient's illness or injury. (All elements of the above definition must be met before an item can be considered to be durable medical equipment.) Without limiting the forgoing, durable medical equipment does not include: arch supports and orthotics; consumables; computer-assisted communication devices; exercise equipment; car lifts or stair lifts; biofeedback equipment; self-help devices which are not medical in nature (regardless of the relief they may provide for a medical condition); air conditioners and air purifiers; whirlpool baths, hot tubs, and saunas; waterbeds; other equipment which is not always used for healing or curing; computerized and "deluxe" equipment (such as motor-driven wheelchairs or beds) when standard equipment is adequate; medical equipment required primarily for use in athletic activities; equipment or items which are experimental or investigational, or not Medically Necessary; equipment or an item which replaces equipment or an item that is still functional, in good repair or under warranty and does not offer additional therapeutic benefit; equipment or an item which replaces lost or stolen durable medical equipment; duplicate equipment purchased primarily for the patient's convenience when the need for duplicate equipment is not medical in nature. Durable medical equipment also does not include repairs to rental equipment, or services and supplies primarily for personal comfort, hygiene, or convenience and not primarily medical in nature. Furthermore, the Plan must authorize in advance any items of durable medical equipment that will exceed a total billed amount of $2,000, and the Plan reserves the right to select the durable medical equipment provider.

- Physical therapy and physiotherapy.
- Prosthetic devices (other than a dental device or device that may be considered an artificial implant) that replace all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of permanently inoperative or malfunctioning internal body organ, when furnished on a Physician's order.
- Medical dressings (adjuncts used for application to a wound to promote healing and/or prevent further harm, designed to be in direct contact with the wound) prescribed or applied by a licensed health care provider other than a licensed practical nurse.
- Professional ambulance service to the nearest Hospital (as described below) with appropriate facilities where necessary care and treatment can be provided.
- Professional nursing services performed at the patient's home by a registered graduate nurse (other than a member of the patient's family) on the recommendation of a Physician; provided the services could not be performed by a nurse's aide, personal care aide, home health care aid, or licensed practical nurse. (The Plan does not cover charges for hospice care, or for services of a nurse's aide, personal care aide, home health care aide, or licensed practical nurse.)
- Dental treatment from a Physician or dentist at a Hospital required because of an accidental injury to sound natural teeth caused by external trauma to the face or mouth (not treatment for cracked or broken teeth that result from biting or chewing), and which occurs while covered under the Plan.
- Hospital and anesthesiology (but not Physician) services for the removal of teeth at a

Hospital.

- Cardiac rehabilitation after coronary surgery supervised by a Physician.
- Expenses associated with reconstructive surgery following a mastectomy; reconstructive surgery on the other breast to achieve symmetry; and prostheses and the treatment of physical complications at any stage of the mastectomy including lymphedemas.
- Medically Necessary, FDA approved Gene Therapy. Any such therapy or treatment must be authorized in advance by the Plan and is subject to a twenty (20%) percent co-insurance payment and the normal Deductible Amount. Gene Therapy means therapy that involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or turning off genes that cause medical problems.

Exclusions. Expenses related to any of the following are specifically excluded as Covered Expenses and are not paid by the Plan. Notwithstanding the foregoing, where required by the No Surprises Act, none of the exclusions in this section will apply to Emergency Services for an Emergency Condition. (*See* ***Protection from Surprise Bills***.) These exclusions are in addition to expenses excluded under other provisions of the Plan.

- Any service, treatment, technology, procedure, care, drug, appliance, equipment, device, supply or other item (whether provided on an outpatient or in-patient basis) for treatment of substance abuse or a mental, nervous, psychological, emotional or anxiety disorder or condition. For purposes of the Plan, a "mental, nervous, psychological, emotional or anxiety disorder or condition" is any disease, disorder or condition which manifests itself through mental, nervous, psychological, emotional or anxiety symptoms, regardless of whether the origin of the condition is physical, mental, psychological, emotional or otherwise.
- Hospice care.
- Surgery, treatment and services performed by a nurse's aide, personal care aide, home health care aide, or licensed practical nurse.
- Prescribed drugs in excess of a: (i) 34-day supply if not obtained through the mail-in prescription drug card program; or (ii) 90-day supply if obtained through the mail-in prescription drug card program.
- Elective, cosmetic or beautifying surgery, except when made necessary by trauma, congenital disease or an abnormality of a Child which has resulted in a functional defect.
- An elective abortion, including by drugs.
- Surgery, services and drugs related to, or to treat the pregnancy of, any person other than a Participant or a Participant's Spouse.
- Surgery, treatment, services and drugs for impotency.
- Surgery, treatment, services and drugs for infertility, including in-vitro fertilization.
- Surgery, treatment and services for artificial implants, except: (i) in connection with reconstructive surgery following a mastectomy; (ii) surgically implanted pacemakers to stimulate or regulate contractions of the heart muscle; (iii) stents; and (iv) hip and

knee replacements.

- Hearing exams and evaluations (whether or not performed in connection with the need for a hearing aid), and assistive listening devices.
- Acupuncture treatment and services.
- Surgery, treatment and services for reversal of a tubal ligation or vasectomy.
- Radial keratotomy, PRK and lasik surgery in excess of the allowance for all vision benefits described below (see **Vision Benefits** under **Special Rules and Limits** below).
- Except as provided below in the list of Covered Expenses (under **Special Rules and Limits, Arch Supports and Custom Orthotics)** arch supports and orthotic appliances.
- Surgery, treatment services and drugs for artificial organ implantation (but not for natural organ transplantation).
- Any drugs not approved by the Food and Drug Administration
- Medicines, and other items not prescribed by a Physician and dispensed by a pharmacy, except as stated below with regard to medicines and drugs which are prescribed, but may be available without a prescription, and are intended to assist a Participant, Spouse or Eligible Child to stop smoking (see **Smoking Cessation Benefits** under **Special Rules and Limits** below).
- Except as provided below in the list of Covered Expenses (under **Special Rules and Limits, Cranial Hair Prostheses),** surgery, treatment, services and drugs related to hair loss.
- Surgery, treatment, services, and drugs related to gender change.
- Surgery, treatment, services, drugs, supplies and equipment provided at any facility that is not a Hospital.
- Nutritional and weight loss programs, unless the program is conducted in conjunction with counseling from, and supervised by, a licensed health care provider.
- Education, training, custodial care, maintenance and home care services.
- Skilled nursing facilities.
- Speech therapy.
- Dental surgery, treatment or services, except as stated above.
- Surgery, treatment, services, drugs, supplies and equipment covered by "No-Fault" automobile insurance.
- Surgery, treatment, services, drugs, supplies and equipment performed, administered, provided or purchased for an injury or sickness incurred in connection with the commission of a crime, offense, or other act which violates federal, state or local law, whether or not there is any prosecution for the crime, offense or other act.
- Surgery, treatment, services, drugs, supplies and equipment performed, administered, provided or purchased for an injury or sickness due to the injured or sick person's misconduct.
- Surgery, treatment, services, drugs, supplies and equipment performed, administered, provided or purchased for an injury or sickness for which a contributing factor was the use of alcohol, or the use of any drug in violation of any federal, state or local law whether or not there is any prosecution for the use of the drug.
- Surgery, treatment, services, drugs, supplies and equipment performed, administered,

provided or purchased for an injury, sickness or other condition that is self-inflicted, unless the injury or sickness results from a physical or mental health condition.

- Surgery, treatment, services, drugs, supplies and equipment performed, administered, provided or purchased for an injury, sickness or other condition incurred as a result of any war or act of war, whether declared or undeclared.
- Hospital confinement, surgery, treatment, services, drugs, supplies and equipment performed, administered, provided or purchased before Plan Coverage becomes effective or after Plan Coverage expires.
- Surgery, treatment, services, drugs, supplies and equipment performed, administered, provided or purchased for an injury or sickness resulting from an occupational accident.
- Surgery, treatment, services, drugs, supplies and equipment covered by Worker's Compensation.
- Medical care or services furnished by the Veteran's Administration to a veteran of the United States Armed forces in connection with the treatment of a service connected disability which was incurred or aggravated in the line of duty in the active military, naval, or air service.
- Medical care or services furnished at an armed forces facility to an armed forces retiree or his dependents under the Civilian Health and Medical Program for the Uniformed Services, but only to the extent that person would not have to pay for such medical care or services if he did not have Plan Coverage.
- Surgery, treatment, services drugs, supplies and equipment for which a Participant is not legally required to pay.
- Except as specifically provided above, any surgery, treatment, services, drugs, supplies and equipment that is not Medically Necessary for the diagnosis or treatment of an injury, illness or medical condition, or to improve the function of a malformed body member.
- Any surgery, treatment, services, drugs supplies and equipment performed, administered, provided or purchased in connection with, or as result of complications from, any surgery, treatment, services or drugs not covered by the Plan.
- Surgery, treatment, services and drugs which are determined by the Board to be experimental or investigational. A surgery, treatment, service or drug may be determined to be experimental or investigational even if it has received governmental approval or is ordered by a provider. Experimental or investigational means: (i) it is considered experimental or investigational by any appropriate technological assessment body established by a state or federal government; (ii) it does not have appropriate governmental or regulatory approval when it is provided; (iii) reliable evidence shows that it is not customarily recognized as standard medical treatment for a condition; or (iv) reliable evidence shows that it is, or there is consensus among experts that it should be, the subject of further study or ongoing clinical trials to determine maximum tolerated dosage; toxicity; safety; effectiveness; or effectiveness as specifically compared with the standard means of treatment or diagnosis for a condition. Reliable evidence includes: (i) the views and practices of medical or dental communities throughout the country; (ii) reports and articles published in authoritative medical, dental, and scientific literature; (iii) the opinion of professional consultants; (iv) written protocols used by health care providers studying the service or substantially the same service; and (v) informed consent forms used by health care

providers studying the service or substantially the same service.

- Any other surgery, services, treatment, drugs, supplies and equipment not expressly covered by the Plan.

Special Rules and Limits. The following Covered Expenses are also subject to the special provisions, rules and limits described below.

- **Arch Supports and Custom Orthotics**. Subject to the applicable Deductible Amount (for Covered Expenses that are not in-patient Hospital charges) and a 20% Co-insurance payment, for each Participant, Spouse and Eligible Child, the Plan pays for arch supports and custom orthotic appliances with a total cost of up to $1,000 and purchased during any five (5) consecutive year period (based on date of first purchase) that starts on or after May 1, 2015; provided, the arch supports or custom orthotic appliances are prescribed by a Physician or other licensed health care professional.

- **Chiropractic Care**. The Plan pays the cost of chiropractic services (osteopathic manipulations and spinal adjustments) for each Participant, Spouse and Eligible Child, up to a maximum payment of $40 per visit for up to 12 visits in each calendar year.

- **Cranial Hair Prostheses**. For each Participant, Spouse and Eligible Child, the Plan pays up to a life-time benefit of $500 for cranial hair prostheses (wigs) prescribed on or after May 1, 2015 by a Physician or other licensed health care professional to compensate for hair loss due to chemotherapy or radiation.

- **Contraceptives for Women**. The Plan pays for the following contraceptive methods for women if prescribed by the Physician, with no Deductible Amount, Co-payment or Co-insurance payment requirement: Implantable Rod; IUD Cooper; IUD with Progestin; Shot/Injection; Oral Contraceptives (combined pill); Oral contraceptives (Progestin only); Oral Contraceptives (extended/continuous); Patch; Vaginal Contraceptive Ring; Diaphragm with Spermicide; Sponge with Spermicide ; Cervical Cap with Spermicide; Female Condom; Spermicide Alone; Plan B, Plan B One Step or Next Choice; and Ella. However, prior approval from the Plan's pharmacy benefit manager is required for payment for certain contraceptive drugs and devices, regardless of the method used to purchase them (i.e., even if not purchased using the prescription drug card program). Upon request, the Plan Office will provide a Participant, Spouse or Eligible Child with a list of contraceptive drugs and devices requiring prior approval (and the criteria for approval). You can also contact the Plan's pharmacy benefit manager, Envisions Rx at Envision Pharmaceutical Services, LLC, 2181 East Aurora Road, Suite 201, Twinsburg, OH 44087 (Tel. No. 330-405- 8089), for more information.

- **Hearing Aids**. Subject to the applicable Deductible Amount (for Covered Expenses that are not in-patient Hospital charges) and a 20% Co-insurance payment, for each Participant, Spouse and Eligible Child, the Plan pays for hearing aid(s) (not assistive listening devices) with a total cost of up to $5,000 and purchased during any five (5) consecutive year period (based on date of first purchase) that starts on or after May 1, 2015; provided the hearing aid(s) are prescribed by a Physician or other

licensed health care professional. The Plan reserves the right to select the hearing aid provider. The Plan does not pay for hearing exams and evaluations or the cost of hearing aid batteries, maintenance, and service.

- **Hospital Room, Board, Services and Supplies**. Subject to the in-patient Deductible Amount for in-patient Hospital charges, the Plan pays for Hospital room, board, services and supplies in connection with each Hospital stay (including days in a semi-private room) for treatment other than treatment of substance abuse or a mental, nervous, psychological, emotional or anxiety disorder or condition. (For purposes of the Plan, a "mental, nervous, psychological, emotional or anxiety disorder or condition" is any disease, disorder or condition which manifests itself through mental, nervous, psychological, emotional or anxiety symptoms, regardless of whether the origin of the condition is physical, mental, psychological, emotional or otherwise.) The cost of a private room is covered up to the normal amount for a common semi-private room rate. For purposes of the Plan:

  - Hospital room and board means bed, linen, storage of personal possessions, bathroom and washing facilities, meals, general duty nursing and any and all other services regularly furnished by the Hospital as a condition of occupancy in the class of accommodations occupied. It does not include professional services of Physicians or intensive nursing care, whatever name these services may be called; and

  - Hospital services and supplies means services and supplies furnished to the patient and required for treatment. It does not include room and board, professional services of a Physician, special nursing services or special medication, regardless of whether furnished under the direction of the Hospital or otherwise.

- **Immunizations**. For each Participant, Spouse and Eligible Child, the Plan pays the cost of immunizations at a retail pharmacy participating in the Plan's prescription drug program or at a Physician's office (whether in connection with a routine physical examination or a separate office visit).

- **Kidney Transplants**. The Plan does not cover expenses related to a kidney transplant if: (i) the transplant is experimental or investigational in nature; (ii) the transplant facility is not approved by The Centers for Medicare and Medicaid Services (CMS) as meeting institutional coverage criteria for the transplant; (iii) the transplant is not determined to be Medically Necessary and appropriate by the transplant facility (in accordance with CMS criteria); (iv) the recipient has some immediate life threatening condition apart from the condition for which the transplant is Medically Necessary and appropriate; or (v) the recipient has demonstrated non-compliance with medical recommendations which places the success of the transplant at risk. The Plan also does not cover expenses related to complications arising from kidney transplant surgery not covered by the Plan. In addition, any transplant related expenses not identified below as Covered Expenses are not paid by the Plan. Covered Expenses related to a kidney transplant are limited to:

-registry fee(s);

-medical expenses related to the pre-transplant testing and evaluation to identify a preferable match from a recognized/authorized transplant testing or procurement organization;

-laboratory and other tests needed to evaluate the recipient's medical condition for transplant surgery;

-expenses incurred in the evaluation and procurement of cadaveric kidneys by the organ procurement organization;

-charges for harvesting the kidney (but not harvesting or storage of a kidney in anticipation of a future but un-identified medical need or therapy);

-inpatient services in a certified CMS transplant facility; and

-the following living donor expenses, but only to the extent not covered under any other Health Plan (as defined in Section 6 (**Coordination of Benefits**), but regardless of whether the Health Plan would be the Primary Plan under the COB rules in Section 6): (i) laboratory and other tests needed to evaluate the medical condition of potential living donors; (ii) living donor medical fees, anesthesia and surgical services directly related to the donation surgery in a certified CMS transplant facility; and (iii) expenses incurred by the transplant facility for routine living donor follow-up for a maximum period of ninety (90) days following the donation surgery.

In all cases, the Plan's payment for a Covered Expense is based only on the Reasonable and Customary Charge, and Covered Expenses are subject to the recipient's applicable Deductible Amount, and any applicable Co-Insurance Payment, Co-Payment, Out-of-Pocket Maximum, and the provisions and rules in Section 6 (Coordination of Benefits, Right of Recovery and Subrogation).

- **Maternity Care**. The Plan pays for the following maternity care provided to a Participant or a Participant's Spouse: routine obstetrical care up to the Reasonable and Customary Charge for pre- and post-natal care and delivery; and complications of pregnancy such as toxemia with convulsions, pernicious vomiting, extra-uterine pregnancy or any complication requiring intra-abdominal surgery. However, expenses for diagnostic x-rays, laboratory tests and examinations are subject to a 20% Co-insurance payment.

- **Oral Appliances for Sleep Apnea**. Subject to the applicable Deductible Amount (for Covered Expenses that are not in-patient Hospital charges) and a 20% Co-insurance payment, for each Participant, Spouse and Eligible Child, the Plan pays for oral appliances for treatment of sleep apnea with a total cost of up to $1,000 and purchased during any five (5) consecutive year period (based on date of first purchase) that starts on or after January 1, 2017; provided, the sleep apnea is diagnosed by a Physician and the oral appliance is provided by a Physician, dentist or other licensed health care professional.

- **Prescription Drugs**. The prescription drug coverage described below is available to Participants who are Employees, and their Spouses and Eligible Children. It is also available to a Participant who is an Eligible Former Employee, his Spouse and Eligible Children if the Eligible Former Employee or, if he is married, his Spouse, is not eligible for Medicare Part D prescription drug coverage. There is no prescription drug coverage under the Plan for an Eligible Former Employee, his Spouse or Eligible Children who is eligible for Medicare Part D prescription drug coverage if the Eligible Former Employee either has no Spouse or has a Spouse who is also eligible for Medicare Part D prescription drug coverage.

  For as long as the Plan offers a prescription drug card program, the Participant, his Spouse or his Eligible Child may present a prescription card at a retail pharmacy participating in the program and pay a: (i) $5 Co- payment for up to a 34-day supply of drug covered under the Plan and classified as a generic prescription drug by Plan's pharmacy benefit manager; (ii) $15 Co-payment for up to a 34-day supply of a drug covered under the Plan and classified as a preferred prescription drug by Plan's pharmacy benefit manager; or (iii) $30 Co-payment for up to a 34-day supply of a drug covered under the Plan and classified as a non-preferred prescription drug by Plan's pharmacy benefit manager.

  If the Participant, his Spouse or Eligible Child uses the mail-in prescription drug card program, the Co-payment is: (i) $12.50 for up to a 90-day supply of a drug covered under the Plan and classified as a generic prescription drug by Plan's pharmacy benefit manager; (ii) $37.50 for up to a 90-day supply of a drug covered under the Plan and classified as a preferred prescription drug by Plan's pharmacy benefit manager; or (iii) $75 for up to a 90-day supply of a drug covered under the Plan and classified as a non-preferred prescription drug by Plan's pharmacy benefit manager.

  If a Participant, his Spouse or Eligible Child does not purchase prescription drugs at a retail pharmacy participating in the prescription drug card program or through the mail-in prescription drug card program, or the Plan stops offering a prescription drug card program, the Plan pays the cost of up to a 34-day supply of a prescription drug covered under the Plan with a 20% Co-insurance payment.

  Prior approval from the Plan's pharmacy benefit manager is required for certain drugs, regardless of the method used to purchase the drugs. Upon request, the Plan Office will provide a Participant, Spouse or Eligible Child with a list of prescription drugs requiring prior approval, and a list of generic, preferred and non-preferred prescription drugs. You can also contact the Plan's pharmacy benefit manager, Elixir Rx Solutions, LLC, P.O. Box 1206, Twinsburg, OH 44087 (Tel. No. (800) 361-4542), for more information.

- **Specialty Medications.** The Plan will only cover the cost of Specialty Medication prescriptions filled through Elixir Rx Solutions, LLC.

  Specialty Medications are used to treat complex, chronic conditions, such as multiple sclerosis and rheumatoid arthritis and are those medications classified as such by the

Plan's pharmacy benefit manager. A list of Specialty Medications is available upon request from the Plan Office or you may contact the Plan's pharmacy benefit manager, Elixir Rx Solutions, LLC, P.O. Box 1206, Twinsburg, OH 44087 (Tel. No. (800) 361-4542).

Prior authorizations and/or step therapies may be required for Specialty Medications as indicated on the Plan's formulary.

All Specialty Medication prescriptions will be subject to a 20% Co-insurance payment, up to a maximum of $250 per prescription.

Co-insurance payments for Specialty Medications, and Specialty Medications filled at a pharmacy other than Elixir Rx Solutions, LLC will be excluded when determining whether the Plan's overall Out-of-Pocket Maximum has been reached and will not be covered after the Out-of-Pocket Maximum has been reached.

- **Preventive Health Screening and Routine Physical Examination**. For each Participant, Spouse and Eligible Child, the Plan pays the cost of: (i) one preventive health screening (arranged by the Plan Office) per calendar year; and (ii) one routine physical examination (including radiology and laboratory procedures associated with the annual examination visit) per calendar year.

- **Smoking Cessation Benefits**. For each Participant, Spouse and Eligible Child over the age of 18, the Plan pays for medicines and drugs prescribed by a Physician and intended to assist the Participant, Spouse or Eligible Child to stop smoking (determined without regard to whether the medicine or drug is available without a prescription). Whether a medicine or drug is a prescribed medicine or drug will be determined in accordance with regulations and other guidance issued by the Internal Revenue Service.

- **Surgery**. The Plan pays the lesser of the Reasonable and Customary Charge or the billed charge for surgery performed by a surgeon. Expenses for pre- and post-operative care are included in the Reasonable and Customary Charge for the surgery and are not covered as separate charges. If two or more surgical procedures are performed at the same time, by the same health care provider and under the same anesthesia, the Plan pays the normal amount for the most expensive procedure, 50% of the normal amount for the next most expensive procedure, and 25% of the normal amount for the other procedure(s); provided documentation supports that each procedure requires a separate excision, separate lesion, or separate injury (or area of injury in extensive injuries) or different site or organ system. If two or more surgical procedures are performed through the same surgical opening, the Plan pays the normal amount for the most expensive procedure and does not pay for the less expensive procedure(s).

  For purposes of the Plan, surgery means specific surgery to remedy a specific injury or ailment, and surgeon means a doctor of medicine who is legally qualified to practice medicine and perform surgery in accordance with all applicable laws.

In addition to the amount payable for a surgeon's services, the Plan will pay for the services of a surgeon assisting in a required procedure, up to 20% of the Reasonable and Customary Charge for the primary surgeon's services.

- **Vision Benefits**. For each Participant, Spouse and Eligible Child, the Plan pays: (i) the cost of an eye examination every 12 consecutive months performed by a legally qualified optometrist, ophthalmologist or optician; and (ii) 100% of the Plan's allowance for frames, prescribed glass lenses and prescribed contact lenses, plus 10% of the cost in excess of the Plan's allowance. The Plan's combined allowance for prescribed glass lenses and prescribed contact lenses is $300 every 12 consecutive months.

  For Participants, Spouses and Eligible Children who have reached the age of 19, the Plan will pay the cost of radial keratotomy, PRK or lasik surgery, and related follow up treatment or subsequent surgery (including treatment or surgery arising from complications from initial surgery). However, this benefit is subject to a maximum of $300 for all such expenses incurred during any consecutive 12-month period and the amount the Plan pays is reduced by any amount of the Plan pays for frames, prescribed glass lenses or prescribed contact lenses during the same 12- month period.

Protection From Surprise Bills

A 'Surprise Bill' is a bill you receive for a Covered Expense in the following circumstances:

(1) Emergency Services performed by a non-Network Provider with respect to an Emergency Condition;

(2) Air ambulance services performed by a non-Network Provider; and

(3) For certain non-Emergency Services performed by a non-Network Provider at a participating Hospital, ambulatory surgical center and Independent Freestanding Emergency Department.

There are special reimbursement rules that apply to Surprise Bills when determining the Plan's payment to the non-Network Provider. These special reimbursement rules will always apply to the following covered non-Emergency Services when performed by a non-Network Provider at an In-Network Hospital, ambulatory surgical center or Independent Freestanding Emergency Department:

(1) Covered services performed by a non-Network Provider when a Network Provider is unavailable at the time the healthcare services are performed at the In-Network Hospital, ambulatory surgical center or Independent Freestanding Emergency Department;

(2) Covered services performed by a non-Network Provider as a result of unforeseen, urgent medical issues that arise at the time such services are performed, even if you previously consented to the non-Network Provider performing such services;

(3) Covered services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;

(4) Covered services provided by assistant surgeons, hospitalists, and intensivists; and

(5) Diagnostic services, including radiology and laboratory services.

A Surprise Bill does not include a bill for healthcare services when a Network Provider is available and you elected to receive services from a non-Network Provider or, with respect to non-Emergency Services (other than those specified above) performed by a non-Network Provider in a participating Hospital, ambulatory surgical center or Independent Freestanding Emergency Department if the non-Network Provider has obtained your consent to receive the services after providing you with required notice and satisfying all other consent requirements applicable to the non-Network Provider. If the non-Network Provider follows the notice and consent requirements and you consent to receiving the services, the Plan's normal reimbursement rules with respect to non-Network Providers will apply with regard to those services and you may be balance billed. Please see the definition of 'Allowable Expense' for information about the Plan's normal reimbursement rules.

For Surprise Bills, the Plan will reimburse the non-Network Provider an initial payment equal to the Recognized Amount. You will be held harmless for any non-Network Provider charges for the Surprise Bill that exceed your cost-sharing under the Plan (i.e. Copayment, Deductible or Coinsurance) for Network Providers. Your cost-sharing will be calculated based off of the Recognized Amount and will count towards your In-Network Deductible, if any, and your In-Network Out-of-Pocket Maximum.

For purposes of this Section, the 'Recognized Amount' means the lesser of the billed charges or the 'Qualifying Payment Amount.' The 'Qualifying Payment Amount' is the amount determined by the Plan in accordance with the requirements of 29 CFR 2590.716-3.

The provisions specified in this Section and in the Plan are designed to comply with the group health plan requirements of the No Surprises Act. The provisions are based on regulations published by the U.S. Department of the Treasury, Department of Labor, and Department of Health and Human Services (the "Departments") and will be interpreted to be consistent with those regulations. If the Departments issue additional guidance regarding the requirements of the No Surprises Act, the Plan will comply with the additional or modified requirements as required by such guidance.

To the extent the Plan provides coverage for air ambulance or Emergency Services for an Emergency Condition and the cost-sharing applied to such air ambulance services or Emergency Services when rendered by a non-Network Provider is different than the cost-sharing applied when such services are rendered by an Network Provider, to the extent necessary to comply with the No Surprises Act, the Plan will apply the same cost-sharing to air ambulance services or Emergency Services for an Emergency Condition when rendered by a non-Network Provider as the cost-sharing that is applied to such services when rendered by a Network Provider.

Continuing Care

If you are in an ongoing course of treatment when your Network Provider leaves the network, then you may continue to receive covered services for the ongoing treatment from the former Network Provider for up to 90 days from the date your provider's contractual obligation to provide services to you under the Plan terminates. If you are pregnant, you may continue care with a former Network Provider through delivery and postpartum care directly related to the delivery.

The Provider must accept as payment the negotiated fee that was in effect just prior to the termination of the relationship of the provider with the network. The Provider must also provide the Plan with necessary medical information related to your care and adhere to any policies and procedures established by the Plan, including those for assuring quality of care and obtaining preauthorization and a treatment plan approved by the Plan. You will receive covered services as if they were being provided by an Network Provider and will be responsible only for any applicable cost-sharing.

In addition to the above, if you are considered a 'continuing care patient' and any benefits under the Plan are terminated because of a change in the terms of participation of your Provider in the network, you will be given notice of such change or termination and will have the right to elect to continue coverage under the Plan, with respect to that Provider, under the same terms and conditions that were in effect on the date you are given notice of the provider's change in network status or termination of benefits as a result of change in network participation. If you elect to continue such coverage under the Plan, coverage for transitional care with respect to that provider will be provided under those same terms and conditions only for the period ending on the earlier of (1) 90 days from the date the notice is provided or (2) the date you are no longer considered a 'continuing care patient'. In addition, coverage under those same terms and conditions during this period of transitional care is limited to the condition for which you were receiving care from your provider, that qualifies you as a 'continuing care patient,' prior to the provider's change in network status.

For purposes of this section, you are a 'continuing care patient' if you meet any of the following conditions:

(1) You are undergoing a course of treatment for a 'serious and complex condition.' For this purpose, 'serious and complex condition' means:

a. An acute illness that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

b. A chronic illness that is life threatening, degenerative, potentially disabling or congenital and requires specialized medical care for a prolonged period of time.

(2) You are undergoing a course of institutional or inpatient care from the provider.

(3) You are scheduled to undergo non-elective surgery, including post-operative care from the provider.

(4) You are pregnant and undergoing a course of treatment for the pregnancy from the provider.

(5) You are terminally ill (as defined in Section 1861 of the Social Security Act) and receiving treatment for the terminal illness from the provider.

Please note, if the Provider was terminated by the network due to fraud, imminent harm to patients, or a final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

SECTION 6
COORDINATION OF BENEFITS
RIGHT OF RECOVERY AND SUBROGATION

Coordination of Benefits. If an Employee. Spouse or Eligible Child is covered under this Plan and another Health Plan (as defined below), the following coordination of benefits ("COB") rules determine how much of a Covered Expense (as described in Section 5 (**Health Benefits**)) this Plan should pay when there is a claim.

A Participant, his Spouse or Eligible Child may be required to identify and provide information regarding all of his Health Plan coverage so that the Plan can determine whether it is the "Primary Plan" (the Plan that pays the claim first) or "Secondary Plan." For purposes of the COB rules, "Health Plan" means any: individual, group, fraternal, blanket or franchise insurance policy; health maintenance organization (HMO) contract; other form of group or non group-type coverage (whether insured or uninsured); health care components of long-term care contracts, such as skilled nursing care; coverage under a group or individual automobile contract; Medicare; and any other governmental plan, program or coverage provided by federal or state statute. However, it does not include any coverage for which federal law prohibits coordination of benefits with this Plan.

When a person is covered under more than one Health Plan, the "Primary Plan" and the "Secondary Plan" are determined using the following rules applied in the order below (i.e., the first rule to apply will control).

- A Health Plan that does not contain or apply COB rules consistent with this the COB rules in this Plan is always the Primary Plan.

- If one Health Plan covers the person as other than a dependent (e.g., as an employee, member, policy holder, subscriber or retiree) and another Health Plan covers the person as a dependent, the Health Plan not covering the person as a dependent is the Primary Plan and the Health Plan covering the person as a dependent is the Secondary Plan. However, if the person is a retiree and a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Health Plan covering the person as a dependent and primary to the Health Plan not covering the person as a dependent, then the Health Plan not covering the person as a dependent is the Secondary Plan and the other Health Plan is the Primary Plan. If the person is an active employee and a Medicare beneficiary and, as a result of federal law, Medicare is secondary to both Health Plans, then the Health Plan covering the person as a dependent is the Secondary Plan and the other Health Plan is the Primary Plan.

- Unless a court decree states otherwise, if a dependent child is covered by both his parents' Health Plans and:

  (1) the child's parents are married or are living together (whether or not they have ever been married), the Health Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan or, if both parents have the same birthday, the Health Plan that has covered a parent the longest is the Primary Plan.

(2) the child's parents are divorced, separated or not living together (whether or not they have ever been married) and:

(i) a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage, the Health Plan of that parent is the Primary Plan for the child;

(ii) a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the Health Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan for the child or, if both parents have the same birthday, the Health Plan that has covered a parent the longest is the Primary Plan for the child;

(iii) a court decree states that the parents have joint custody without specifying which parent has responsibility for the health care expenses or health care coverage of the child, the Health Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan for the child or, if both parents have the same birthday, the Health Plan that has covered a parent the longest is the Primary Plan for the child; or

(iv) there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the Primary Plan for the child will be:

- the Health Plan covering the custodial parent or, if no Health Plan covers the custodial parent,

- the Health Plan covering the spouse of the custodial parent or, if no Health Plan covers the spouse of the custodial parent,

- the Health Plan covering the non-custodial parent or, if no Health Plan covers the non-custodial parent,

- the Health Plan covering the spouse of the non-custodial parent.

The custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

This rules above applicable in the case of a court decree apply to calendar months after this Plan is given notice of the court decree

- If the child is covered under more than one Health Plan of individuals who are not both parents of the child, the rules above apply as if those individuals were the parents of the child.

- If a person is covered by a Health Plan as an active employee (e.g., an employee who is neither laid off nor retired), or as a dependent of an active employee, and is covered by another Health Plan as an inactive employee (or as a dependent of an inactive employee), the Health Plan covering the person as an active employee, or as a dependent of an active employee, is the Primary Plan, and the Health Plan covering the person as an inactive employee (or as a dependent of an inactive employee) is the Secondary Plan.

- If a person is covered by a Health Plan pursuant to COBRA or similar state law and is covered by another Health Plan as a member, policy holder, subscriber, active employee or retiree, the Health Plan covering the person as a member, policy holder, subscriber, active employee or retiree is the Primary Plan and the other Health Plan is the Secondary Plan.

- If a person is covered by a Health Plans as a member, policy holder, subscriber, active employee or retiree, the Health Plan covering the person as a member, policy holder, subscriber, active employee or retiree for the longer period of time is the Primary Plan and the Health Plan covering the person as a member, policy holder, subscriber, active employee or retiree for the shorter period of time is the Secondary Plan.

- If the rules above do not determine the order of benefits, the Allowable Expenses (as defined in below) are shared equally between the Health Plans; provided, however, that this Health Plan will not pay more than it would have paid had it been the Primary Plan.

The Primary Plan pays benefits before, and without regard to, those of any Secondary Plan. A Secondary Plan determines its benefits after those of the Primary Plan, and may reduce the benefits it pays so that all Health Plan benefits do not exceed 100% of total Allowable Expenses. Generally, an Allowable Expense is a health care expense, including deductibles, co-insurance payments and co-payments, covered at least in part by a Health Plan. If a Health Plan provides benefits in the form of services, the reasonable cash value of each service is considered an Allowable Expense. Any expense that a provider by law or in accordance with a contract is prohibited from charging a covered person is not an Allowable Expense.

A Secondary Plan may reduce its benefits so that the total benefits paid or provided by all Health Plans during a Plan Year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other Health Plans and apply that calculated amount to any Allowable Expense that is unpaid by the Primary Plan. However, the Secondary Plan may reduce this amount so that its payment, when combined with the amount paid by the Primary Plan, does not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan will credit against its deductible amounts any amounts it would have credited against its deductible in the absence of other Health Plan coverage.

Payment made under another Health Plan may include an amount that should be paid under this Health Plan. In that event, this Health Plan will pay that amount directly to the Health Plan that made the payment. That amount will then be treated as though it were a benefit paid under this Health Plan,

and this Health Plan will not have to pay that amount again. If benefits are provided in the form of services, "payment made" means the reasonable cash value of the benefits provided in the form of services.

If the amount of the payments made by this Plan (including the reasonable cash value of any benefits provided in the form of services) is more than it should have paid, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person.

Contact the Plan Office if you have any questions about the COB rules of if you would like a complete copy of the Plan's COB rules.

Right of Recovery. If payments are made by the Plan that exceed the amount payable under any Plan provision, limit or rule, the Board has the right to recover the excess from the person who received the payments, the person for whom the payments were made, or from any insurance company or other party that owes payment for the expense for which the excess payment was made. The Board also reserves the right to decrease (up to the amount of the excess payment) any future benefits otherwise payable under the Plan to the Participant who benefited from the excess payment.

Subrogation. When the Plan pays Covered Expenses incurred by a Participant, Spouse or Eligible Child, it is subrogated to any right the Participant, Spouse or Eligible Child (and his legal representative, heirs or beneficiaries) may have to a recovery from any third party that caused the injury or sickness for which the Covered Expense was incurred, or under State workers' compensation laws. The Plan's subrogation rights will not be diminished or otherwise affected if the total recovery received is less than the amount necessary to make the Participant, Spouse or Eligible Child whole for all of the expenses and other damages related to the injury or sickness. However, the amount that must be paid to the Plan will be reduced by a proportional share of the verified legal fees and expenses paid to obtain the recovery.

Furthermore, payment of any such Covered Expense is conditioned upon the Participant, Spouse and/or Eligible Child (and his legal representative, heirs and beneficiaries): (i) immediately notifying the Plan of any legal action against the third party or any State workers' compensation claim; (ii) promptly responding to Plan requests for information about the status of any such action or claim; (iii) immediately notifying the Plan of any recovery (whether as a result of an award, settlement or otherwise); (iv) promptly providing an accounting of any proceeds recovered; (v) taking other reasonable action requested by the Plan to help secure and enforce the Plan's subrogation rights (including executing documents, and consenting to the Plan's intervention in an action against the third party); (vi) not acting in any manner that prejudices the Plan's subrogation rights; and (vii) if requested by the Plan, participating in an expedited arbitration proceeding to resolve any dispute regarding the Plan's subrogation rights.

The Plan may also offset payment of other Covered Expenses incurred by the Participant, Spouse or Eligible Child by the amount of any such recovery, in which case the Plan will relinquish its right to reimbursement from the recovery by the amount offset.
Acceptance of Covered Expense payments (directly or by payment to a health care provider) constitutes agreement by the Participant, Spouse or Eligible Child (and his legal representative, heirs or beneficiaries) to the terms and conditions above. The Board may also require the Participant, Spouse and/or Eligible Child (and his legal representative, heirs or beneficiaries) to sign a written

instrument acknowledging the Plan subrogation rights and these terms and conditions before paying a Covered Expense. However, the Plan's subrogation rights will not be diminished if the Plan does not require such a separate written agreement.

Alienation and Qualified Medical Child Support Orders. The rights of Participants, Spouses and Eligible Children under the Plan are not subject to assignment, attachment, garnishment, or alienation, except as provided in a qualified medical child support order (as defined in the Employee Retirement Income Security Act of 1974). (This provision does not preclude payment of an approved claim for a Covered Expense directly to a health care provider if the Participant, Spouse or Eligible Child authorizes the payment.) A qualified medical child support order is an order by a court for one parent to provide a child or children with health coverage. If the Plan receives such an order for your child or children, you will be contacted about the procedure for the order. Copies of the Plan's qualified medical child support order procedure are available, without charge, from the Plan Office.

SECTION 7
LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

General. The Plan pays the accidental dismemberment benefits described below if a Participant is injured while he has Plan Coverage, and the death benefits described below if he or his Spouse or Eligible Child dies while he has Plan Coverage. Any claim for death or accidental dismemberment benefits must be received by the Plan within 18 months after the death or injury occurs.

Death Benefits. Except as provided below (see **Special Rule for Eligible Former Employees** and **Death and Dismemberment Benefit Exclusions** below), the death benefit payable if a Participant dies while he has Plan Coverage is $8,000, unless death is due to an accident, in which case the death benefit is $16,000. A Participant may designate a beneficiary to receive this benefit on a form provided by the Plan Office. A properly completed death beneficiary designation form will become effective when filed with the Plan, and will remain in effect until a new form is filed. If a Participant does not file a beneficiary designation form, any death benefit payable on account of his death will be paid to his surviving Spouse or, if he has no surviving Spouse, to his estate.

Except as provided below, the death benefit (payable to a Participant) when his Spouse dies while the Participant has Plan Coverage is $2,000 (regardless of the cause of death), and the death benefit (payable to a Participant) when his Eligible Child dies while the Participant has Plan Coverage is $1,500 (regardless of the cause of death).

Accidental Dismemberment. Except as provided below (see **Special Rule for Eligible Former Employees** and **Death and Dismemberment Benefit Exclusions** below), the Plan will pay a Participant a benefit equal to the benefit payable upon his death by accidental injury if he suffers an accidental bodily injury while he has Plan Coverage resulting in the loss of: (i) both hands; (ii) both feet; (iii) one hand and one foot; or (iv) the sight of both eyes. Except as provided below, the Plan will pay a Participant a benefit equal to one-half of the benefit payable upon his death by accidental injury if he suffers an accidental bodily injury while he has Plan Coverage resulting in the loss of: (i) one hand; (ii) one foot; or (iii) the sight of one eye. For purposes of the Plan, loss of sight means total and irrecoverable loss of sight; loss of a hand means severance of the hand at or above the wrist; and loss of a foot means severance of the foot at or above the ankle.

Special Rule for Eligible Former Employees. Notwithstanding the above, if an Eligible Former Employee: (i) is eligible for Medicare Part D prescription drug coverage; (ii) has no Spouse or has a Spouse who is also eligible for Medicare Part D prescription drug coverage; and (iii) is paying the special Self-Payment amount determined by the Board for Plan Coverage (see **Self-Payment** in Section 4 (**Plan Coverage**)), the benefit payable under the Plan in the event of his death is $4,000, regardless of the cause of death. Furthermore, the death benefit payable in the event of the death of a Spouse of such an Eligible Former Employee is $2,000 (regardless of the cause of death), and the death benefit payable in the event of the death of an Eligible Child of such an Eligible Former Employee is $1,500 (regardless of the cause of death). Also these Eligible Former Employees are not eligible for any accidental death or dismemberment benefits.

Death and Dismemberment Benefit Exclusions. Notwithstanding the above, no death benefit or accidental dismemberment benefit is payable under the Plan for any death or dismemberment that occurs in connection with the commission of a crime or in connection with self-inflicted injuries or suicide, while sane or insane.

No Conversion. At no time can the death benefit coverage or accidental dismemberment coverage under the Plan be converted to individual coverage after the Participant's Plan Coverage terminates.

SECTION 8
REIMBURSEMENT ACCOUNTS

Reimbursement Account Participation and Credits. This Section 8 contains provisions that apply to Participants' Reimbursement Accounts.

- If, as of the end of the month, the number of Credit Hours in an Employee's Initial Eligibility Hour Bank exceeds the number needed to satisfy the Minimum Hour Requirement for Initial Eligibility, the excess Credit Hours are converted to a dollar amount and credited to his Reimbursement Account; provided, however, that no amount is credited to a Participant's Reimbursement Account unless he is enrolled in Plan Coverage (as defined in Section 3 (**Definitions**)) at the time it is credited. The amount credited to his Reimbursement Account equals the number of such excess Credit Hours (after an increase if the Contribution Rate for the Hours is greater than the Minimum Contribution Rate) multiplied by the Minimum Contribution Rate.

- Only the first 150 Hours worked by an Employee in a calendar month are credited to a Participant's Continuing Eligibility Hour Bank. Any Hours that would be credited but for this 150 Hour maximum are converted to a dollar amount and credited to his Reimbursement Account at the time those Hours would have otherwise been credited to his Continuing Eligibility Hour Bank; provided, however, that no amount is credited to a Participant's Reimbursement Account unless he is enrolled in Plan Coverage (as defined in Section 3 (**Definitions**)) at the time it is credited. The amount credited to his Reimbursement Account equals the number of such Hours in excess of 150 multiplied by the Contribution Rate for those Hours. (For purposes of determining this excess, no Hours credited to an Employee prior to May 2000 are considered.)

- If the Contribution Rate for Hours credited to a Participant's Continued Eligibility Hour Bank is greater than the Minimum Contribution Rate, the excess amount is also

credited to his Reimbursement Account at the time those Hours are credited; provided, however, that no amount is credited to a Participant's Reimbursement Account unless he is enrolled in Plan Coverage (as defined in Section 3 (**Definitions**)) at the time it is credited. The amount credited to his Reimbursement Account equals the number of those Credit Hours multiplied by the difference between: (i) the Contribution Rate; and (ii) the Minimum Contribution Rate.

- An Employee or former Employee eligible to have medical expenses paid or reimbursed from his Reimbursement Account may permanently waive Reimbursement Account coverage (and future Reimbursement Account payments and reimbursements) by completing and filing with the Plan Office a waiver form provided by the Plan Office. A participation waiver form filed by an Employee or former Employee will be effective (and will apply to any and all medical expenses incurred for the Employee or former Employee, his Spouse or any of his Children) on and after the date it is filed.

- A Spouse or Child eligible to have his medical expenses paid or reimbursed from his Reimbursement Account may permanently waive Reimbursement Account coverage (and future Reimbursement Account payments and reimbursements for his own medical expenses) by completing and filing with the Plan Office a waiver form provided by the Plan Office. A participation waiver form filed by a Spouse or Child will be effective (and will apply to his own medical expenses incurred) on and after the date it is filed.

Reimbursement Account Claims. Subject to the following rules, a Participant may file a claim for payment or reimbursement from his Reimbursement Account for a medical expense incurred for: (i) himself; (ii) his Spouse; (iii) a person who qualifies as his dependent (as determined for purposes of Section 105(b) of the Code) at the time the Eligible Expense is incurred; or (iv) a person who qualifies as his child (as determined for purposes of Section 105(b) of the Code) at the time the Eligible Expense is incurred, but only through the end of the calendar year in which the child attains age twenty-six (26).

- An expense is eligible for payment or reimbursement from a Participant's Reimbursement Account only if:

  - it is not otherwise paid by the Plan (i.e., is not a Covered Expense) and is not payable or reimbursable under any other health plan, policy, program, or from any other source;

  - would be allowable as a deduction for federal income tax purposes if it were not being reimbursed (but without regard to the requirement that medical expenses exceed a percentage of adjusted gross income);

  - except as provided below, it is not an individual or group insurance premium;

  - in the case of an expense incurred for a Participant, the expense is incurred on or after the date the Participant has Plan Coverage;

- in the case of an expense incurred on or after May 1, 2017 for a person who qualifies as a Participant's Spouse, dependent or child (as described above) that person has Plan Coverage when the expense is incurred; and

- the claim for the expense is received by the Plan within 12 months after the expense is incurred (i.e., the date the service, treatment, drug, supply or equipment is provided). However, if:

    - a Participant files a timely claim, in accordance with the Plan's claim procedure, asserting that part or all of an expense is a Covered Expense that qualifies for payment by the Plan independent, and without use, of his Reimbursement Account, and the claim is denied;

    - the Participant files a timely request for review of the denied claim, in accordance with the Plan's claim procedure, and the denial is upheld upon review;

    - the Participant makes the same claim in a legal action against the Plan, commenced within one year after the date a written notice of the decision on review is sent in accordance with the Plan's claim procedure (or, if no written notice of the decision on review is sent by the date required under the claim procedure, within one year after the date such notice should have been sent), and a final ruling is issued by a court rejecting the claim; then

    - the Participant has 6 months after the final court ruling to file a claim for payment or reimbursement of the expense from his Reimbursement Account.

- The minimum amount that may be claimed for expenses incurred during the 12-month period before the date the claim is filed is $100. However, during the first calendar quarter of every year, a Participant may file a claim of up to $100 for expenses incurred during the previous calendar year.

- A claim must be filed with the Plan on forms provided by the Plan Office.

- If a claim is approved in whole or in part, payment or reimbursement will be made for the approved amount up to the amount in his Reimbursement Account, and the amount paid or reimbursed will immediately be deducted from his Reimbursement Account.
- If a claim is denied in whole or in part because there are insufficient funds in the Reimbursement Account, the Participant must file another claim within the time period described above for payment or reimbursement of the expense (or the remaining portion of the expense) when additional funds are credited to the Reimbursement Account.

- Once four claims are filed in the same calendar year for payment or reimbursement of medical expenses from a Reimbursement Account, a $20 administration fee will apply

and automatically be taken from the Reimbursement Account for each additional claim filed during that calendar year.

The following examples show how some of the rules above work. Note that if there is, or appears to be, any discrepancy between the rules above and the examples below, the rules control your right to reimbursement from your Reimbursement Account.

Example 1: A Participant purchases non-prescription drugs for a medical condition. These expenses are not eligible for reimbursement because he cannot deduct them on his federal income tax return.

Example 2: A Participant pays the Deductible Amount, Co-insurance payment or Co- payment for a Covered Expense (i.e., an expense otherwise covered under the Plan). This payment is eligible for reimbursement from his Reimbursement Account if it is not covered under any other health plan, policy or program. If it is reimbursed from his Reimbursement Account, he cannot deduct the Deductible Amount, Co-insurance payment or Co-payment on his federal income tax return. Note that this example assumes the Covered Expense is incurred when the Participant has a Reimbursement Account balance.

Example 3: A Participant incurs a $300 medical expense not covered by the Plan. If this is the type of medical expense allowable as a deduction for federal income tax purposes and it is not covered under any other health plan, policy or program, it is eligible for reimbursement from his Reimbursement Account. (However, if it is reimbursed from his Reimbursement Account, he cannot deduct the expense on his federal income tax return.) Note this example assumes the medical expense is incurred on or after the date the Participant has Plan Coverage and when he has a Reimbursement Account balance.

Example 4: A Participant incurs a medical expense on August 1, 2019 but is not yet enrolled in Plan Coverage. In October 2019 he has Plan Coverage and files a claim for the expense from his Reimbursement Account. The claim is denied because the expense was incurred before he had Plan Coverage.

Example 5: A Participant's dependent incurs a medical expense on August 1, 2019. This Participant is enrolled in Plan Coverage on August 1, 2019, but his dependent is not. In October 2019, he files a claim for the expense from his Reimbursement Account. The claim is denied because the expense was incurred when his dependent did not have Plan Coverage.

Use of Reimbursement for Self-Payment. If a Participant qualifies for Self-Payment for Plan Coverage, he may use up to the amount credited to his Reimbursement Account to satisfy the Self-Payment amount required. Use of a Reimbursement Account to Self- Pay is subject to the following rules.

- By the 15th day of the month for which the Participant does not satisfy the Minimum Hour Requirement for Continued Eligibility, he must notify the Plan Office (on a form provided by the Plan Office), that he wants to use his Reimbursement Account for all or part of the Self-Payment amount, and the amount he wants to use.

- Any portion of the required Self-Payment amount not in and paid from the Reimbursement Account must be paid directly by the Participant by the 15th day of the

same month.

- Any amount in the Reimbursement Account used for Self-Pay will immediately be deducted from the Reimbursement Account.

The following example shows how the rules above work. If there is, or appears to be, any discrepancy between the rules above and the example below, the rules control your right to Self-Pay and Plan Coverage. Note that the example assumes the Minimum Hour Requirement is 150 Hours and the Minimum Contribution Rate is $5.40 per Hour (the Minimum Contribution Rate as of July 1, 2019).

Example: A Participant's entire Hour Bank is used to satisfy the Minimum Hour Requirement for Continued Eligibility for July 2019. He has $1,000 in his Reimbursement Account. No Hours are credited to him in July 2019. By August 15, 2019, he must file a form with the Plan Office stating he wants to use his Reimbursement Account and/or Self-Pay (with after-tax dollars) for Plan Coverage in August 2019. If the Plan Office receives the completed form by August 15, 2019 stating he wants to use his Reimbursement Account for Plan Coverage, $810 (150 x $5.40) will be deducted from his Reimbursement Account and he will have Plan Coverage in August 2019. If the Plan Office receives the completed form by August 15, 2019 stating he wants to use only part of his Reimbursement Account for Plan Coverage and wants to Self-Pay the rest for August 2019, an amount equal to $810 minus the amount of any Self-Payment received with the form will be deducted from his Reimbursement Account and he will have Plan Coverage in August 2019. If the Plan Office does not receive the completed form by August 15, 2019, his Plan Coverage will end as of July 31, 2019 and he will not be eligible for Plan Coverage again until he is an Employee and again satisfies the Minimum Hour Requirement for Initial Eligibility.

Note: The Plan offers Participants the option of automatically deducting amounts credited to their Reimbursement Accounts to pay for Plan Coverage. To do this, the Participant must complete, sign and file an election form with the Plan Office. The election applies for the month the Plan Office receives the completed and signed form, provided the form is received by the Self-Payment due date for the month. Otherwise the election applies the following month. If a Participant's Reimbursement Account balance is less than the full amount he is required to Self-Pay, his entire Reimbursement Account balance will be used to partially pay for Plan coverage if he directly Self-Pays the remainder. The election remains in effect until the Participant completes, signs and files a revocation notice with the Plan Office. The revocation notice applies the month after the month the Plan Office receives the completed and signed notice, and each month thereafter. Election forms and revocation notices can be obtained from the Plan Office.

Death of Employee. Claims may be made for payment from a deceased Participant's Reimbursement Account for expenses incurred by his Spouse or his Eligible Children. The Participant's surviving Spouse must file claims for her expenses and expenses for all Eligible Children, in accordance with the rules above. If there is no surviving Spouse, each Eligible Child (or his legal guardian) may file claims for that Eligible Child's own expenses, and all claims are processed in the order received.

The following examples show how this rule works. Note that if there is, or appears to be, any discrepancy between the rule above and the example below, the rule controls your right to reimbursement from your Reimbursement Account.

Example 1: A Participant dies with money credited to his Reimbursement Account. He is survived

by his Spouse and two Eligible Children. Only the surviving Spouse can file claims on his Reimbursement Account after he dies.

Example 2: A Participant dies in October 2019 with money credited to his Reimbursement Account. He was not married at the time of his death, but is survived by two children. On December 10, 2019, child A files a claim for reimbursement, and on December 20, 2019, child B files a claim for reimbursement. Child A's claim will be processed first and, if there is still money credited to the Reimbursement Account, child B's claim will then be processed.

Forfeiture of Reimbursement Accounts. The amount in a Participant's Reimbursement Account is forfeited at the end of any twenty-four (24) consecutive month period during which: (i) the Participant does not qualify for Plan Coverage; (ii) no Employer reports Hours for the Participant; and (iii) no claims are made on the Reimbursement Account. At approximately the eighteen (18^{th}) month of such a period, the Plan Office will mail a notice to the Participant's last known address (or if the Participant is deceased to the last known address of his surviving Spouse or Eligible Children) stating that the amount in his Reimbursement Account will be forfeited at the end of the 24-month period.

The following examples show how this rule works. Note that if there is, or appears to be, any discrepancy between the rule above and the example below, the rule controls the right to reimbursement from your Reimbursement Account.

Example 1: An Employee's last day of Plan Coverage is October 31, 2019, when he has $200 in his Reimbursement Account. He does not file a claim on the Reimbursement Account and he does not work for a contributing Employer through November 1, 2021. He forfeits the $200 on November 1, 2021.

Example 2: Assume in the example above that the Employee does work for a contributing employer during August and September 2021, but the Employer does not report the Hours until after November 1, 2021. The Employee still forfeits the $200 on November 1, 2021.

Example 3: An Employee dies on October 31, 2019 while he has Plan Coverage and with $500 in his Reimbursement Account. If no claim is made on his Reimbursement Account by November 1, 2021, the $500 will be forfeited on November 1, 2021.

Example 4: An Employee dies on December 15, 2019 with $400 in his Reimbursement Account. He last had Plan Coverage on June 30, 2019. No Hours were reported for him after June 2019, and no claims were made on his Reimbursement Account from July 1, 2019 to the date he died. If no claim is made on his Reimbursement Account by June 30, 2021, the $400 will be forfeited on July 1, 2021.

SECTION 9
CLAIM PROCEDURE

Health Claims

A claim for payment or reimbursement from a Participant's Reimbursement Account must be received by the Plan Office within 12 months after the expense is incurred (i.e., the date the service, treatment, drug, supply or equipment is provided). A claim for a Covered Expense (i.e., a health care expense that qualifies for payment by the Plan in accordance with Section 5 (**Health Benefits**)) must be received by the Plan Office within 90 days after the Covered Expense was incurred unless it can be shown to the satisfaction of the Board that the claim was made as soon as reasonably possible. However, in no event will the Plan pay for a Covered Expense if the claim is not made within 18 months after the date the Covered Expense was incurred.

Payment for services rendered by a non-Network Provider that are subject to the surprise billing protections as described in the 'Protection from Surprise Bills' section of the Plan will be made directly to the non-Network Provider.

The claim procedures are different for "concurrent claims," "pre-service claims," "post- service claims," and "urgent claims." A concurrent claim is a request for an extension of health treatment (i.e., treatment provided over a period of time or a number of treatments). A pre-service claim is a claim requiring advance approval to receive all or part of the benefit. (Note that advance approval from the Plan's pharmacy benefit manager is required for certain drugs and contraceptive devices.) Upon request, the Plan Office will provide a list of prescription drugs requiring advance approval, and a list of generic, preferred and non-preferred prescription drugs. This information can also be obtained from the Plan's pharmacy benefit manager, Elixir Rx Solutions, LLC, at P.O. Box 1206, Twinsburg, OH 44087 (Tel. No. (800) 361-4542). A post-service claim is any claim that is not a concurrent claim or pre-service claim.

An urgent claim is any claim for medical care or treatment that, if non-urgent claim procedures were followed, could seriously jeopardize the life or health of the patient or his ability to regain maximum function, or in the opinion of a physician with knowledge of the patient's medical condition would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested.

A Participant may appoint someone to file a claim and act on his behalf; provided he gives the Plan signed written notification of the appointment. In the case of an urgent claim, a health care professional with knowledge of the patient's medical condition will be permitted to act as the representative.

All claims, except urgent claims, must be submitted to the Plan Office on form(s) approved by the Plan Office, with all applicable sections completed and signed by the claimant, together with itemized bills for the expenses incurred. However, urgent claims may be made orally and information may be transmitted by telephone or facsimile, provided that any necessary forms are later completed and filed. The phone numbers are (716) 664-4391 (telephone) and (716) 483-0677 (facsimile).

If you make a claim for benefits that does not comply with the Plan's procedure for pre- service claims, you will be notified of the proper procedure within 24 hours if it involves an urgent pre-service claim, or within five days if it involves a non-urgent pre-service claim. (This notification may

be oral, unless you request written notification.)

If a claimant fails to submit sufficient information for a determination on an urgent claim, he will be notified of the specific information necessary to complete the claim within 24 hours after the Plan receives the claim. He may then submit the additional information within 48 hours, and will be notified of the determination on his claim within 48 hours after the earlier of the receipt of the additional information or the end of the period the additional information could have been submitted.

A claimant will be notified of the determination on his claim within: 24 hours in the case of a concurrent claim involving urgent health care if the claim is received at least 24 hours before the scheduled expiration of the treatments; 72 hours in the case of any other urgent claim (or earlier if possible); 15 days in the case of a non-urgent pre-service claim; or 30 days in the case of a post-service claim. However, if an extension to make a determination on a non-urgent pre-service claim is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to another 15 days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected. Also, if the extension is necessary because additional information is needed from the claimant, the claimant will be given 45 days from the date he receives the notice to provide the information.

If an adverse determination is made, the claimant will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the determination; (iv) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (v) a description of the Plan's review procedures and time limits; (vi) a statement that the claimant has a right to sue under Section 502 of the Employee Retirement Income Security Act (ERISA) following an adverse determination upon review; (vii) if the Plan relied upon an internal rule, guideline, protocol or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and that a copy of the criterion is available free of charge upon request; (viii) if the determination was based upon medical necessity, experimental or investigational treatment (or similar exclusion or limit), either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant's medical circumstances), or a statement that such explanation will be provided free of charge upon request; and (ix) for urgent claims, a description of the expedited review procedure for such claims. This notice may be provided orally for an urgent claim, but will then be sent to the claimant in writing within three days after oral notification.

Within 180 days after receiving an adverse determination, a claimant may file a written appeal with the Plan Office for a full and fair review of the claim and determination. He may submit written comments, documents and other information relating to the claim, and may have (free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to the claim. For an urgent claim, the claimant may request, in writing or orally, an expedited review of the initial determination, and information may be transmitted by telephone or by facsimile, provided that any necessary written forms are later completed and filed. The phone numbers are (716) 664-4391 (telephone) and (716) 483-0677 (facsimile).

A reduction or termination of health treatment (other than by Plan amendment or termination) will be treated as an adverse determination, and the Participant or beneficiary will be notified sufficiently in

advance to allow him to appeal before the reduction or termination occurs.

The review on appeal will: (i) not afford any deference to the initial adverse determination; (ii) take into account all documents, records and information submitted by the claimant; (iii) be conducted by an appropriate named fiduciary who did not make the initial determination and who is not a subordinate of the person who did; and (iv) provide for the identification of any medical or vocational experts whose advice was obtained by the Plan in connection with the initial adverse determination (without regard to whether the advice was relied upon in making the initial adverse determination). For a claim based on medical judgment (e.g., whether a treatment or drug is experimental, investigational, or Medically Necessary or appropriate), the person conducting the review will consult with a state licensed or certified independent health care professional with appropriate training and experience in the field who was not consulted in connection with the initial determination and is not a subordinate of any health care professional who was consulted.

The claimant will be notified of the determination on review within 72 hours after the Plan receives the request for review of an urgent claim (or earlier if possible), or 30 days after the Plan receives a request for review of a non-urgent pre-service claim.

For a post-service claim, the Board will make the determination on review no later than the date of its meeting immediately following the Plan's receipt of a request for review, unless the request for review is received within the 30 day period preceding that meeting (in which case, the determination on review will be made no later than the date of its second meeting following the Plan's receipt of the request for review). However, if special circumstances require a further extension of time, the determination on review may be made as late as the third meeting following the Plan's receipt of the request for review. If an extension is required because of special circumstances, before the extension begins the claimant will receive a written notice of the extension (including a description of the special circumstances and the date as of which the determination will be made). The claimant will receive written notice of the determination on review as soon as possible, but not later than five days after, it is made.

The notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a statement that, upon request, the claimant is entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; (iv) if the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request; (v) if the determination is based upon medical necessity, experimental or investigational treatment (or similar exclusion or limit), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (vi) the following statement "External Review of an adverse benefit determination will be available for a denial that involves consideration of whether the Plan is complying with the PROTECTION FROM SURPRISE BILLS section of the Plan."

External Review

You may file a request for an external review by an independent review organization (IRO) for a denial that involves consideration of whether the Plan is complying with the PROTECTION FROM SURPRISE BILLS section of the Plan.

A request for an external review must be made no later than four months following the date you receive a notice of a final adverse benefit determination.

Within five business days following receipt of your external review request, the Plan must complete a preliminary review of your request. If the appeal is granted, the Plan must assign an IRO to conduct the external review and will submit all information to the IRO.

Within one business day following the preliminary review, the Plan must issue a written notification to you indicating the status of your request. If additional information is required, the written notification will include a description of the material or information necessary for you to perfect your external review request within the four-month filing period.

Upon receipt of the material or information requested, the Plan will review the information and forward it to the IRO within one business day. If, upon receipt of this information, the Plan reverses the internal adverse benefit determination, the Plan must send written notification to the IRO and to you within one business day after making such a decision. The assigned IRO must terminate the external review upon receipt of the notice from the Plan Office.

For any other appeal not reversed by the Plan, the IRO must provide written notice of the final external review decision within 45 days after receipt of the request for external review. The IRO must deliver this final notice to you and the Plan Office. The decision of the IRO shall be the final decision of the Plan.

The IRO will conduct their review and will not be bound by any decisions or conclusions previously reached by the Plan Office.

Expedited External Review
The external review process will be expedited if:

1. You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or

2. The internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service which you received on an emergency basis, but have not yet been discharged from a facility.

Upon receipt of your request for expedited external review, the Plan must immediately verify eligibility for external review, issue a notification in writing to you, and assign an IRO. The IRO is required to provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision within 48 hours after the date of providing that notice to you and the Plan Office.

Death or Dismemberment Benefit Claims

All claims for death or dismemberment benefits must be submitted to the Plan Office in writing within 30 days after the death or dismemberment, if possible, or otherwise as soon as possible. A claim for

a death benefit must be accompanied by an original death certificate. An authorized representative may file a claim on behalf of the claimant; provided the claimant gives the Plan signed written notification of the appointment. The claimant will be notified of the determination on his claim within 90 days. However, if an extension to make a determination is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to another 90 days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected.

If an adverse determination is made, the claimant will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; a description of the Plan's review procedures and time limits; and (v) a statement that the claimant has a right to sue under Section 502 of the Employee Retirement Income Security Act (ERISA) following an adverse determination upon review.

Within 60 days after receiving an adverse determination, a claimant may file a written appeal to the Plan Office for a full and fair review of the claim and determination. He may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The review on appeal will take into account all documents, records and information submitted by the claimant. The claimant will be notified of the determination on review within 60 days after the Plan receives a request for review. However, if an extension to make a determination on review is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to another 60 days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected.

The notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; and (iii) a statement that, upon request, the claimant is entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim.

Examinations. The Plan reserves the right to have a Physician selected by the Board examine a Participant, Spouse or Eligible Child with respect to whom benefits under the Plan have been claimed, or to require that a Participant, Spouse or Eligible Child obtain a second Physician's opinion that any service, treatment, drug, supply or equipment is Medically Necessary. In the case of death, the Plan reserves the right to have an autopsy performed if not forbidden by law.

Legal Action. Any legal action brought against the Plan, any Plan employee, the Board or any Trustee by a Participant, Spouse, Eligible Child or other person to recover any benefit from the Plan, may be filed only after timely complying with and exhausting the claim procedure described in this Section 9 (including the written appeal procedure) and:

- if no written denial of the claim is sent by the date required under the claim procedure, within one year after the last date a written denial should have been sent in accordance with the claim procedure; or

- within one year after the date a written notice of the decision on review is sent in accordance with the claim procedure or, if no written notice of the decision on review

is sent by the date required under the claim procedure, within one year after the last date a written notice of the decision on review should have been sent in accordance with the claim procedure.

Furthermore, any such legal action must be brought in the United States District Court for the Western District of New York.

SECTION 10
POWERS OF THE TRUSTEES

In addition to the authority and power conferred upon it by law, the Board has the power and discretion to:

- To construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

- Establish, amend, modify and revoke, the rules, terms and provisions of the Plan, including eligibility for coverage, termination of coverage, and any and all other matters which it deems necessary or proper to carry out the purpose and intent of the Plan.

- Establish and, from time to time, change the Minimum Contribution Rate and/or Minimum Hour Requirement, as it deems necessary or appropriate to preserve the financial integrity of the Plan or to carry out the purpose and intent of the Plan.

- Establish and, from time to time, increase, decrease or otherwise modify or eliminate specific benefits under the Plan, as it deems necessary or appropriate to preserve the financial integrity of the Plan or to carry out the purpose and intent of the Plan.

- Administer the Plan in all of its details, including the authority to: (i) decide any issues of fact relevant to the eligibility of any person to receive benefits under the Plan, or the amount or time of payment of benefits under the Plan; (ii) interpret the terms of the Plan; (iii) supply any omission, interpret any ambiguous or uncertain provisions of the Plan, and reconcile any inconsistency that may appear in the Plan; and (iv) make and enforce such rules and regulations as it deems necessary or proper for the administration of the Plan.

- Enter into reciprocal agreements with other plans of similar nature, and industry-wide agreements involving other plans, which provide for the exchange of contributions with respect to employees covered under one plan who work in the jurisdiction of another plan.

- Rescind a person's Plan Coverage (i.e., retroactively cancel or discontinue Plan Coverage) if the person (or another person who sought Plan Coverage for the person) performed an act, practice, or omission that constitutes fraud, or made an intentional misrepresentation of fact, to get the Plan Coverage; provided, however, any person whose Plan Coverage is rescinded will receive at least 30 days prior written notice of

the rescission and the rescission will be considered an adverse benefit determination for purposes of the Plan's claim and review procedures.

SECTION 11
YOUR RIGHTS

COBRA Coverage

Introduction

This Section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. It explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the Spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your Spouse dies;

- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's Spouse, surviving Spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

<u>When is COBRA Continuation Coverage Available?</u>

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and Spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Southern Tier Building Trades Benefit Plan Office, 202 W. Fourth Street, Jamestown, NY 14701.

<u>How is COBRA Continuation Coverage Provided?</u>

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified

beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. The notice must be in writing, and must contain your name and address, the name and address of the disabled qualified beneficiary, and the date the disability was determined to have begun. You must also attach a copy of the SSA determination. You may be asked to provide additional documentation or information after you have submitted the notice.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the Spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the Spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and

Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Information about the Plan and COBRA continuation coverage can be obtained from the Southern Tier Building Trades Benefit Plan Office, 202 W. Fourth Street, Jamestown, NY 14701 (Telephone No. (716) 664-4391).

Maternity Benefits

Under Federal law, the Plan generally may not restrict benefits for any Hospital length of stay in connection with childbirth to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section, and may not require that a health care provider obtain authorization from the Plan for prescribing a length of stay not greater than these periods.

FMLA Coverage

Notwithstanding any other provision of this Plan, if an Employee with Plan Coverage qualifies for leave from his employment with his Employer under the Family Medical Leave Act ("FMLA"), he may continue Plan Coverage during such leave in accordance with the FMLA, provided he would have been continuously employed during the entire leave period.

HIPAA Privacy Rules

The Plan has responsibilities under Health Insurance Portability and Accountability Act ("HIPAA") regarding the use and disclosure of your protected health information ("PHI"). Your PHI is any information that: (i) identifies you or may reasonably be used to identify you; (ii) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (iii) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care.

Under HIPAA, the Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan's privacy notice

or more information about the Plan's privacy practices, or you want to file a privacy violation complaint, please contact the Plan Office Administrator, 202 W. Fourth Street, Jamestown, NY 14701 (Telephone No. (716) 664-4391).

Women's Health and Cancer Rights Act

The Plan provides coverage in connection with a mastectomy (in the manner determined by the attending physician and the patient) for:

- reconstruction of the breast on which the mastectomy is performed,
- surgery and reconstruction of the other breast to produce symmetrical appearance, and
- prostheses and physical complications at all stages of the mastectomy, including lymphedema.

ERISA Rights

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants will be entitled to:

Receive Information About Your Plan and Benefits

This includes the ability to:

- 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.
- 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.
- 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.

Continue Group Health Plan Coverage

You may have a right to continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Coverage rights.

You should be provided a certificate of creditable coverage, free of charge, from the Plan or health

insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Coverage, when your COBRA Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 Plan Participants and beneficiaries. No one, including your Employer, your union, 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 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 Plan Administrator. If you have a claim for benefits that 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 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 is frivolous.

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 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.