

**LABOR-MANAGEMENT
HEALTHCARE FUND
HEALTH REIMBURSEMENT
ARRANGEMENT**

Summary Plan Description for
Specialty Copay Assistance Program

Labor-Management Healthcare Fund Health Reimbursement Arrangement Summary Plan Description

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INTRODUCTION

The Labor-Management Healthcare Fund (“LMHF”) is pleased to provide Labor-Management Healthcare Fund Health Reimbursement Arrangement (“HRA Plan”) for Eligible Employees.

This summary plan description describes the basic features of the HRA Plan, how it operates, and how you can get the maximum advantage from it. This is only a summary of the key parts of the HRA Plan and a brief description of your rights as a Participant. If there is any conflict between the official, complete plan document and this summary, the official HRA Plan document will control. Definitions of capitalized terms used in this pamphlet are contained in Part V.

PART I GENERAL INFORMATION

I.1 What is the purpose of the HRA Plan?

The purpose of the HRA Plan is to reimburse Eligible Employees, up to certain limits, for their own, their Spouse’s and their covered Dependents’ Medical Care Expenses (subject to the exclusions in Appendix B). Reimbursements for Medical Care Expenses paid by the Plan generally are excludable from taxable income.

I.2 When did the HRA Plan take effect?

The HRA Plan became effective January 1, 2013.

I.3 Who can participate in the HRA Plan?

You will be an Eligible Employee and able to join the HRA Plan if you are a participant in a LMHF specified medical health plan and enroll in the LMHF specialty Rx Incentive Program (the “Specialty Rx Program”), as outlined in Appendix A. Please contact the Plan Administrator for additional information.

If you are a Participant in the HRA Plan, you may also be reimbursed for eligible Medical Care Expenses incurred by your Spouse and Dependents.

I.4 Are there employees who are not eligible to participate in the HRA Plan?

Yes, there are certain employees who are not eligible to join the Plan. They are:

- Employees who are ineligible for or do not participate in a LMHF specified medical health plan;
- Employees who do not enroll in the LMHF specialty Rx Incentive Program (the “Specialty Rx Program”); and
- Employees who are considered “self-employed individuals” under the federal tax law.

I.5 What benefits are offered through the HRA Plan?

Once you become a Participant, the HRA Plan will maintain an “HRA Account” in your name to keep record of the amounts available to you for the reimbursement of eligible Medical Care Expenses. Your HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest or accrue earnings of any kind. Benefits must first be reimbursed from any health insurance plan before any benefits are payable from this HRA Plan.

Before the start of each Plan Year, the Employer will determine the maximum annual amount that may be credited during that Plan Year to the HRA Accounts of Participants in the HRA Plan. For each Plan Year that you are a Participant, your HRA Account will be credited with the annual maximum amount. This amount will be communicated to Participant’s prior to the start of each Plan Year. The current maximum annual amount is \$400 per Plan Year; however, this amount will be contributed to you quarterly in \$100 increments upon enrollment in the Specialty Rx Program and at the beginning of each calendar quarter that you remain enrolled in the Specialty Rx Program. Your HRA Account will be credited with quarterly contributions on the first of the month at the start of each quarter that you are a Participant.

Your account will be reduced by any amount paid to you, or for your benefit, for eligible Medical Care Expenses. The amount available for reimbursement of Medical Care Expenses as of any given date will be

the total amount credited to your HRA Account as of such date, reduced by any prior reimbursements made to you as of that date.

At the end of the Plan Year, the unused amount (if any) in your HRA Account will remain available and will be added to the next Plan Year's contribution.

Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. A claim expense incurred in one Plan Year can be carried into subsequent Plan Years for reimbursement so long as you were enrolled in the Plan during both Periods of Coverage.

Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage including a health flexible spending account.

I.6 How will the HRA Plan Work?

The HRA Plan will reimburse you for eligible Medical Care Expenses to the extent that you have a positive balance in your HRA Account. The following procedure should be followed:

- You may use the debit card issued with this Plan or you must submit a claim to the Administrator and provide any additional information requested by the Administrator;
- A request for payment must relate to the Medical Care Expenses incurred during the time you were covered under this Plan.

Claims must be submitted in writing (unless a debit card is used). The Administrator may require that Participants submit claims on a form provided by the Administrator. The claim or in the case of a debit card transaction where the Administrator has requested additional information the documentation must set forth:

- The person or persons on whose behalf the Medical Care Expenses were incurred;
- The nature and date of the Medical Care Expenses so incurred;
- The amount of the requested reimbursement; and
- A statement that such Medical Care Expenses have not been otherwise reimbursed and is not reimbursable through any other source.

Each claim must be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such Medical Care Expenses, along with any additional documentation that the Administrator may request.

A debit card is an alternative way of paying for eligible Medical Care Expenses using monies in your HRA Account. You must certify that the debit card will only be used to pay for eligible Medical Care Expenses for you, your Spouse and eligible Dependent(s). You will be required to make this certification each Plan Year. Your failure to do so will prohibit you from enrolling in the debit card program.

In the event that a claim was reimbursed in error, you will be required to reimburse the Employer for the improper payment. If you fail to reimburse the LMHF, the LMHF may withhold the improper amount from your pay, offset any future claims until the improper payment is fully recouped, and restrict or deny your access to the debit card to recoup the improper payment. If the improper payment is not recouped, the LMHF may take any action it would normally take for any other business indebtedness to recoup the improper payment.

I.7 Are there any limitations on benefits available from the HRA Plan?

Only Health Care Expenses are covered by the HRA Plan. A Health Care Expense is an expense that is related to the diagnosis, care, mitigation, treatment or specific prevention of disease. Some examples of eligible expenses are (a) prescription drugs and medicines; (b) physician office visits; (c) dental expenses; and (d) vision expenses. Your Administrator can provide you with more information about which expenses are eligible for reimbursement.

Medical Care Expenses Exclusions. "Medical Care Expenses" shall not include the expenses listed as exclusions under Appendix B to this Summary Plan Description.

Some examples of expenses that are **not** eligible include the following:

- Health Insurance Premiums.
- Vitamins & Nutritional Supplements.
- Cosmetic Surgery.
- Custodial care.
- Cosmetic, toiletries, toothpaste, etc.

I.8 How do I become a Participant?

If you meet the eligibility requirements described in section I.3, you become a participant in this HRA Plan in accordance with procedures established by your Employer; your entry date will be in the same manner as designated by the Plan Administrator for its Specialty Drug Program.

If you or your Spouse or Dependents are eligible for premium assistance under Medicaid or Children's Health Insurance Program, your Employer's health plan is required to permit you and your Spouse or Dependents to enroll in the Plan – as long as you and your Spouse or Dependents are eligible, but not already enrolled in the Employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within sixty (60) days of being determined eligible. You may make a consistent election for such coverage at that time.

I.9 What if I terminate my employment or lose eligibility during the Plan Year?

If you cease to be an Eligible Employee (for example you die, retire, terminate employment, or lose eligibility under the Plan), your participation in the Plan will continue with no additional Employer contributions made for a period of 90 days or, if sooner, until any accrued HRA account balances have been exhausted, unless you elect COBRA coverage as described below.

However, if you are rehired within 30 days after your termination, your HRA Account balance will be reinstated.

I.10 What is COBRA? If I or my spouse have a COBRA Qualifying Event, can I continue to participate in the HRA Plan?

COBRA is a federal law that gives certain employees, Spouses and Dependent children of employees the right to temporary continuation of their health coverage under the Employer's group health plan. If you, your Spouse or your Dependent Children incur an event known as a "Qualifying Event," and if such person is covered under the HRA Plan, then the person incurring such event will be entitled under COBRA (except in the case of small employers) to elect to continue their coverage under the HRA Plan if they pay the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except under the application of COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

- Your termination from employment or reduction of hours;
- Your divorce or legal separation from your Spouse; □
- Your becoming eligible to receive Medicare benefits;
- Your dependent child's ceasing to qualify as a Dependent.

If the qualifying event is termination from employment, then the continuation coverage runs for a period of 18 months following the date that coverage ended. Continuation coverage may be extended to 36 months if another event occurs during the initial 18-month period. You are responsible for informing the Plan coverage may also extend to 29 months in the case of an individual, disabled within 60 days after the date the entitlement to continuation coverage arose and who continues to be disabled at the end of the 18 months. In all other cases to which COBRA applies, continuation of coverage shall be for a period of 36 months.

I.11 What about Family and Medical Leave Act (FMLA)?

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return.

I.12 What about Uniformed Services Employment & Reemployment Rights Act (USERRA)? If you are going into or returning from military service, you may have special rights to health care coverage under your HRA Plan under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

I.13 Will I have any administrative costs under the HRA Plan?

Generally, no. The LMHF is currently bearing the entire cost of administering the HRA Plan while you are an eligible employee.

I.14 How long will the HRA Plan remain in effect?

Although the LMHF expects to maintain the HRA Plan indefinitely, it has the right to terminate the HRA Plan at any time. The LMHF also reserves the right to amend the HRA Plan at any time and in any manner that it deems reasonable, in its sole discretion.

I.15 Are my benefits taxable?

The HRA Plan is intended to meet certain requirements of existing federal laws, under which the benefits that you receive under the HRA Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce different results.

I.16 What happens if my claim for benefits is denied?

If your claim for benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for benefits under the HRA Plan are discussed below.

A. When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within thirty (30) days after the Administrator's receipt of the claim. This 30-day period may be extended by an additional period of up to fifteen (15) days if the extension is necessary due to conditions beyond the control of the Administrator. The Administrator is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of a failure to submit the information necessary to decide the claim, the Administrator will notify you regarding what additional information you are required to submit and you will be given at least forty-five (45) days after such notice to submit the additional information. The Claims Administrator will make a decision within fifteen (15) days after the later of the receipt of the additional information needed to complete the claim or the end of your 45-day period to submit the additional information. If you do not submit the additional information, the Administrator will make the decisions based on the information that it has.

B. What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from the Administrator will include the following information:

- Information specific to identify the claim involved;
- The reason for the denial;
- A reference to the specific Plan provision(s) on which the denial is based;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- A description of the HRA Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring civil action under applicable law following a denial on review;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and
- If the Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, protocol, or a statement that such a rule, guideline, protocol, or similar criteria was relied upon in making the determination and that a copy of such rule, guideline, protocol or similar criterion will be provided to you free of charge upon request.

C. Do I have the right to appeal a denied claim?

Yes, you have the right to appeal the Administrator's denial of your claim.

D. What are the requirements of my appeal?

Your appeal must be in writing, must be provided to the Administrator, and must include the following information:

- Your name and address;
- The fact that you are disputing a denial of a claim or the Administrator's actor omission;
- The date of the notice that the Administrator informed you of the denied claim; and
- The reason(s) in clear and concise terms, for disputing the denial of the claim or the Administrator's act or omission.

You should also include any documentation that you have not already provided to the Administrator.

E. Is there a deadline for filing my appeal?

Yes. Your appeal must be delivered to the Administrator within one hundred eighty (180) days after receiving the denial notice or the Administrator's act or omission. If you do not file your appeal within this 180-day period, you lose your right to appeal.

F. How will my appeal be reviewed?

Any time before the appeal deadline, you may submit copies of all relevant documents, records, written comments, and or other information to Plan Administrator. The HRA Plan is required to provide you with reasonable access to and copies of all documents, records and other information related to the claim. When reviewing your appeal, the Plan Administrator will take into account all relevant documents, records, comments and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination. The appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the initial determination nor an individual who is a subordinate of the individual who made the initial determination. You will be provided with a full and fair review of the claim, and all claims and appeals will be decided in a manner that ensures independence and impartiality of the persons involved in making the decision.

G. When will I be notified of the decision on my appeal?

The Plan Administrator must notify you of the decisions within sixty (60) days after receipt of your request for review.

H. What information is included in the notice of the denial of my appeal?

If your appeal is denied, the notice that you receive from the Plan Administrator will include the following information:

- The reason for the denial upon review;
- A reference to the specific Plan provision(s) on which the denial is based;
- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol, or similar criteria was relied upon in making its review determination, either a copy of the specific rule, guideline, protocol, or a statement that such a rule guideline, protocol, or similar criteria was relied upon in making the review determination and that a copy of such rule, guideline, protocol or similar criterion will be provided to you free of charge upon request; and
- A statement of your right to bring civil action under applicable law following a denial on review; and
- A statement describing any voluntary appeal procedures offered by the Plan and how to obtain information about those procedures.

Upon receipt of a final determination from the Plan, you may have the right to an external review of your claim.

No action may be brought against the Plan, the Employer, the Plan Administrator, or any other entity to which administrative or claims processing functions have been delegated until you first follow the above claim procedures and receive a final determination from the Plan Administrator.

I.17 Who is the Plan Administrator?

The Board of Trustees of the Labor-Management Healthcare Fund is the Plan Administrator and the named fiduciary for the HRA Plan. The Labor-Management Healthcare Fund may appoint a person, entity or committee to administer the Plan.

PART II ADMINISTRATIVE INFORMATION

The Plan Administrator administers the Plan and has the discretionary authority to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage, and benefits. The Plan Administrator's failure to enforce any provision of this Plan shall not affect its right to later enforce that provision or any other provision of the Plan. The Plan Administrator may delegate some of its administrative duties to agents.

The Plan Administrator shall perform its duties as the Plan Administrator in its sole discretion and shall determine what is appropriate in light of the reason and purpose for which the Plan is established and maintained. In particular, the interpretation of all Plan provisions, and the determination of whether a Participant or beneficiary is entitled to any benefit pursuant to the terms of the Plan, shall be exercised by the Plan Administrator in its sole discretion. Any construction of the terms of the Plan for which there is a rational basis that is adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator made in good faith in its sole discretion shall be subject to review only if such an interpretation or other action is without a rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of the review. Any employer that adopts and maintains the Plan, and any employee who performs services for an employer that are or may be compensated for in part by benefits payable pursuant to the Plan, hereby consents to actions of the Plan Administrator made in its sole discretion and agrees to this narrow standard of review.

Name of Plan: Labor-Management Healthcare Fund Health Reimbursement Arrangement

Plan Administrator: Board of Trustees, Labor-Management Healthcare Fund

Plan Administrator's Telephone Number: (716) 601-7980

Plan Administrator's Employer Identification Number: 20-0422657

Plan Number: 511

Plan Year: January 1st through December 31st

Agent for Service of Process: Service may be made on the Plan Administrator at the address listed above.

Claims Administrator:

Name: Nova Healthcare Administrators, Inc.

Address: 511 Farber Lakes Drive
Williamsville, New York 14221

The Financial records of the HRA Plan are kept on a Plan Year basis. The Plan Year ends on each December 31st.

Type of Plan: This Plan is intended to qualify as an employer-provided medical reimbursement plan under Code §§ 105 and 106 and the regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS-Notice 2002-45 and the administration is provided through a third-party claims administrator.

Type of Administration: The Administrator pays applicable benefits from the general assets of the LMHF. The Plan is not funded or insured.

Funding: The HRA Plan is paid for through Employer contributions to the LMHF.

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. The Plan Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Plan Administrator are conclusive and binding. You may contact the Plan Administrator for any further information about the Plan.

PART III HIPAA PRIVACY RIGHTS

Use and Disclosure of Protected Health Information

Except for certain permitted uses and disclosures, the Privacy Rules issued by the federal government prohibits the HRA Plan from using or disclosing certain health information about you that is created or received by the HRA Plan without your written authorization. For additional information about your privacy rights, please either refer to the HRA Plan's Privacy Notice or contact the HRA Plan's Privacy Official.

If you wish to authorize the HRA Plan to use or disclose your PHI in a manner that is not otherwise permitted, you must submit a signed and completed authorization form to the HRA Plan. You may request a copy of the authorization form from Human Resources.

Permitted Uses and Disclosures

The HRA Plan is permitted under the Privacy Rule to use or disclose your PHI without your authorization only for purposes related to:

- Health care treatment;
- Payment for health care;
- Health care operations; and
- Other specifically permitted exceptions, such as disclosures to assist disaster relief, disclosures to lessen serious health or safety threats, or disclosures to business associates.

Disclosures to the Plan Sponsor

After the Plan Sponsor has certified to the HRA Plan that it is in compliance with the Privacy Rule, the HRA Plan may disclose PHI to the Plan Sponsor without your authorization to the extent that the PHI is necessary for the Plan Sponsor to perform HRA Plan administration functions. The HRA Plan may not disclose any more PHI to the Plan Sponsor than is necessary for the Plan Sponsor to fulfill its administration functions, and the HRA Plan may not disclose PHI to the Plan Sponsor for purposes of any employment-related actions or in connection with any other employee benefit provided by the Plan Sponsor.

To the extent that your PHI is disclosed to the Plan Sponsor, the Plan Sponsor will:

- Not use or further disclose PHI, except as permitted or required by the Plan document, or as required by law;
- Ensure that any agent, including any subcontractor, to whom the Plan Sponsor provides PHI or certain electronic media received from the Plan, agree to the restrictions, conditions, and security measures of that apply to the Plan Sponsor with respect to PHI;
- Not use or disclosure PHI for employment-related actions or decisions unless authorized by you;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan provided by the Plan Sponsor unless authorized by you;
- Report to the HRA Plan's Privacy Officer any misuse or improper disclosure of PHI;
- Make PHI available in accordance with the requirements of the Privacy Rule;
- Make PHI available to you for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Rule;
- Make available to you the information required to provide an accounting of disclosures in accordance with the requirements of the Privacy Rule;
- Make internal practices, books and records relating to the Plan Sponsor's use and disclosure of PHI available to the Secretary of Health and Human Services for the purposes of determining the HRA Plan's compliance with HIPAA; and

- If feasible, return or destroy all PHI received from the HRA Plan that the Plan Sponsor still maintains in any form, and retain no copies of the PHI, when the PHI is no longer needed for the purpose for which the disclosure was made

The Plan Sponsor may only disclose your PHI or certain electronic PHI to the following Plan Sponsor employees and may only do so to the extent that the Plan Sponsor’s employees perform HRA Plan Administration functions:

- The Privacy Official
- Employees in the Plan Sponsor’s Human Resources Department □
- Employees in the Plan Sponsor’s Office of General Counsel; and
- Any other class of employees designated in writing by the Privacy Official.

If an employee of the Plan Sponsor does not comply with the requirements of the Privacy Rule, then the Plan Sponsor may apply appropriate sanctions to the employee in order to ensure compliance with the Privacy Rule. If you become aware of any inappropriate use or improper disclosure of PHI, contact the Privacy Official immediately.

PART IV CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called “COBRA continuation coverage”) where coverage under the Plan would otherwise end. This notice is intended to inform Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Participants who become Qualified Beneficiaries under COBRA. The Plan itself can provide group health benefits and may also be used to provide health benefits through insurance. Whenever “Plan” is used in this section, it means any of the health benefits under this Plan.

What is COBRA Continuation Coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Participants and their eligible family members (called “Qualified Beneficiaries”) at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the “Qualifying Event”). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who Can Become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to

have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

- (3) A covered Employee who retired on or before the date of substantial elimination of health coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term “covered Employee” includes any individual who is provided coverage under the Plan due to his or her performance of services for an employer contributing to the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual’s status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual’s Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee’s gross misconduct), or reduction of hours, of a covered Employee’s employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee’s Spouse’s Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse’s coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee’s enrollment in any part of the Medicare program.
- (5) A Dependent child’s ceasing to satisfy the Plan’s requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).
- (6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 (“FMLA”) does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the Procedure for Obtaining COBRA Continuation Coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the Election Period and How Long Must It Last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the employee,
- (3) commencement of a proceeding in bankruptcy with respect to the Employer, or
- (4) enrollment of the employee in any part of Medicare,

IMPORTANT:

For the 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 or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Labor-Management Healthcare Fund
3786 Broadway Street
Cheektowaga, New York 14227

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely 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 for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage would otherwise have been lost (if under your coverage the COBRA period begins on the date of the Qualifying Event, even though coverage actually ends later (e.g., at the end of the month) substitute the appropriate language, e.g. "on the date of the Qualifying Event"). If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

When May a Qualified Beneficiary's COBRA Continuation Coverage Be Terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.

- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What Are the Maximum Coverage Periods for COBRA Continuation Coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

- (4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under What Circumstances Can the Maximum Coverage Period Be Expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36-months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36-months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

Does the Plan Require Payment for COBRA Continuation Coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of any costs. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan Allow Payment for COBRA Continuation Coverage to Be Made in Monthly Installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for Payment for COBRA Continuation Coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to those providing coverage.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of 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 or its designee.

PART V DEFINITIONS

In this document, the following terms, when capitalized, shall have the following meanings unless a different meaning is clearly required by the context.

- *COBRA*. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
- *Committee*. Any Committee, or such other person or entity, as may be appointed by the Employer to supervise the administration of the Plan or decide appeals.
- *Dependent*. Any individual who is a tax dependent of the Participant as defined in Code 152, with the following exception: any child to whom Code 152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents. Notwithstanding the foregoing, the HRA Account will provide benefits in accordance with the applicable requirements of any QMSCO, even if the child does not meet the definition of "Dependent." A child of a Participant shall be considered a "Dependent" up to the end of the Plan Year in which he or she turns age 26, in accordance with Internal Revenue Service Notice 2010-38.
- *Eligible Employee*. An Employee eligible to participate in this Plan, as provided in Section I.3 & I.4.
- *Employee*. An individual that an Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code 414(n)) or any individual classified by an Employer as a contract worker, independent contractor, temporary employee or casual employee for the period during which such individual is so classified, whether or not any such individual is on the W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for an Employer but who has paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any self-employed individual; (d) any partner in partnership; and (e) any more-than-2% shareholder in a Subchapter S corporation, including those deemed to be a more-than-2% shareholder by virtue of Code 318 ownership attribution rules. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits in accordance with Section I.8.
- *Employer*. An Employer that contributes to the Labor-Management Healthcare Fund pursuant to the collective bargaining agreement.
- *Medical Care Expenses*. See Section I-7 for a description of Medical Care Expenses.
- *HRA Account*. The recordkeeping account established in your name by the Employer on the basis of which your eligible Medical Care Expenses will be paid.
- *Participant*. A person who is an Eligible Employee and who becomes a Participant in this Plan.
- *PHI*. This generally includes all information whether written or oral, in connection with the HRA Plan that (1) is created or received by the HRA Plan; (2) relates to your past, present, or future physical or mental health, the provision of health care to you, or the past, present or future payment for the provision of health care; and (3) identifies you or could be used to identify you.
- *Plan*. Labor-Management Healthcare Fund Health Reimbursement Arrangement as amended or restated from time to time.
- *Plan Administrator*. Board of Trustees, Labor-Management Healthcare Fund
- *Plan Year*. 12-month period from January 1st through December 31st.

- *Privacy Rule.* The regulations that were issued by the Department of Health and Human Services in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- *Spouse.* An individual who is legally married to a Participant as determined under the Internal Revenue Code.

PART VI MISCELLANEOUS

EFFECT OF PLAN ON YOUR EMPLOYMENT RIGHTS

The Plan is not to be construed as giving you any rights against the Plan except those expressly described in this document. The Plan is not a contract of employment between you and your Employer.

PROHIBITION AGAINST ASSIGNMENT OF BENEFITS

No benefit payable at any time under this Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment or encumbrance of any kind.

OVERPAYMENT OR ERRORS

If it is later determined that you and/or your Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the HRA Plan.

If you do not refund the overpayment or erroneous payment, the Plan Administrator reserves the right to offset any future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay.

Appendix A LMHF Specialty Rx Incentive Program

Under the LMHF Specialty Rx Incentive Program (the “Program”), you will receive co-pay assistance equal to the otherwise required co-pays for designated drugs. In effect, you will pay nothing for the annual supply of these drugs.

The following specialty drugs obtained through Reliance Rx are currently eligible for incentives under the Program:

A list of eligible specialty drugs can be obtained through Reliance Rx.

In addition, for each calendar quarter you are enrolled in the Program, \$100 will be made available to you in the form of a health reimbursement account which can be used for eligible out-of-pocket medical expenses. This amount is put on a Master Card debit card to pay for qualifying expenses incurred while you are a Participant in a LMHF comprehensive health plan.

You must enroll in the Program and obtain approval from Reliance Rx in order to be eligible for the incentive.

You should call Reliance Rx at (716) 929-1000 or (800) 809-4763 in order to enroll. Telephone lines are open from 8:00 a.m. to 7:00 p.m. Monday through Thursday and from 8:00 a.m. to 5:00 p.m. Fridays.

This Specialty Drug Incentive Program is subject to termination by Reliance Rx or the LMHF at any time.

Appendix B

Exclusions – Medical Expenses That Are Not Reimbursable

The Labor-Management Healthcare Fund Health Reimbursement Arrangement Plan document contains the general rules governing what expenses are reimbursable. This Appendix B, as referenced in the Plan document, specifies certain expenses that *are not reimbursable*, even if they meet the definition of “medical care” under Code 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs.

Exclusions:

The following expenses are not reimbursable, even if they meet the definition of “medical care” under Code 213 and may otherwise be reimbursable under IRS guidance to HRAs.

- Over-the-Counter (OTC) drugs.
- Pregnancy testing kits.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury relating from an accident or trauma, or a disfiguring disease. “Cosmetic Surgery” means any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expense.
- Household and domestic (even though recommended by a physician due to an Employee’s or Dependent’s inability to perform physical housework).
- Massage therapy.
- Home or automobile improvements.
- Custodial care.
- Cost for sending a problem child to a special school for benefits that the child may receive from the course or study and disciplinary methods.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.
- Social activities, such as a dance lessons (even though recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetic, toiletries, toothpaste, etc.
- Vitamins and food supplements, even if prescribed by a physician.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Psychotherapy (including psychoanalysis).
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- An item that does not constitute “medical care” as defined under Code 213.