New Castle Stainless Plate, LLC Retiree Health Reimbursement Arrangement (HRA) Account

Plan Document & Summary Plan Description

Effective January 1, 2022

Contents

Introduction 1
Overview 1
HRA Information 2
Customer Service 3
Overview 3
Eligibility 4
Retiree Eligibility 4
Ineligible Retirees 4
Spouse/Domestic Partner Eligibility 5
Consequences of Coverage of Ineligible Individuals 7
Participating in the Plan 8
Overview 8
When Coverage Ends 9
Overview 9
Reimbursement Account 10
Overview 10
Crediting of Accounts 10
Reimbursements 11
Eligible Expenses for Reimbursement 12
Overview 12
Ineligible Expenses 12
HRA Credits 14
HRA Allocations 14
Claims Procedures 15
Requesting Reimbursement from your HRA Account 15
Your Rights 22
Coordination of Benefits 23
Overview 23
Suspending Your Coverage 24
Overview 24
Continuing Your Coverage 25
General Notice of COBRA Continuation Coverage 25
COBRA Eligibility – COBRA Qualified Beneficiaries 25
COBRA Qualified Beneficiaries 25
Notification of Qualifying Events 26

Employee Retirement Income Security Act (ERISA) Statement of Rights 29
About Your ERISA Rights 29
Important Plan Information 32
Plan Administrator 32
Claims Administrator 32
Benefit Determinations 33
Amendment or Termination 33
Benefit Adjustments 34
Recovery of Overpayment 34
Assignment Prohibited 34
Misconduct 35
Right to Information 35
Funding 35
Plan Expenses 35
Governing Law 36
Satisfaction of Claims 36
Privacy of Protected Health Information 36
General Plan Information 37

Introduction

Overview

New Castle Stainless Plate, LLC (the “Company” and “Plan Sponsor”) hereby adopts the New Castle Stainless Plate, LLC Retiree Health Reimbursement Arrangement (HRA) Account (the “Plan”) for the benefit of its retirees and certain retirees of its participating affiliates. The Plan Sponsor intends the Plan to qualify as a “health reimbursement arrangement” as that term is defined under IRS Notice 2002-45 and a medical reimbursement plan under Section 105 and 106 of the Internal Revenue Code of 1986, as amended (the “Code”), and the Plan will be interpreted at all times in a manner consistent with such intent.

This document is intended to be both the official plan document for the Plan and the summary plan description (”SPD” or “Summary”) for the Plan. To fully understand your benefits, you must read this Summary carefully. It is important that you read the entire Summary. You should keep this Summary for future reference. Share this Summary with your family, particularly any dependents covered under this Plan, and make sure they have read it along with yourself and understand it and your responsibilities. One of your responsibilities is to timely provide any required notice or information as described in this Summary and other benefit communications. Another responsibility is to make sure the Claims Administrator has your current mailing address and to timely notify Company of any change in your address. Failure to follow the terms of the Plan or satisfy any Plan requirements can result in delay, reduction, denial or termination of coverage and/or benefits.

You will notice that certain terms and/or phrases are capitalized throughout this Summary. These terms and/or phrases are important and you should remember them. The capitalized terms and phrases are defined in the Summary.

Neither the receipt of this Summary nor its use of the term “you” indicate that you are eligible to participate in the Plan or receive benefits under the Plan. Only those individuals who satisfy the eligibility requirements and other criteria contained in the Plan are eligible to participate in the Plan. Further, participation in the Plan is not a guarantee of benefits under the Plan.

The information in this Summary may not be relied on as tax advice for any purpose. The Company does not guarantee any specific tax consequences. Ultimately, it is your responsibility to determine whether coverage and benefits provided under this Plan are excludable for tax purposes. For information on how applicable tax law may apply to your personal situation you should consult your own qualified tax advisor.

HRA Information

The Plan is a health reimbursement account, which is an arrangement that you can use to get reimbursed for certain eligible expenses. The arrangement is not a health insurance plan. Nor is it a major medical plan. Instead, the arrangement is designed to work in conjunction with Medicare by allowing you to get reimbursed for eligible premiums and other eligible expenses.

You should be aware that there are deadlines for enrolling in Medicare coverage options. Consequently, if you are planning on retiring or already have done so and will no longer be covered by a group health plan offered by the Company, you should investigate the Medicare enrollment deadlines to ensure that you do not have a gap in coverage. The Company is not responsible for any gap in coverage you may experience.

The Company does not endorse or recommend any particular Medicare plan. Individuals are encouraged to investigate Medicare plans themselves and make their own informed decision about which Medicare plan is best for them. Notwithstanding the foregoing, you should understand that reimbursement is only available through the HRA for policies offered through the Mercer Marketplace. The Medicare plan that you select is your own individual plan and is not sponsored or maintained by the Company and is not part of any plan or program established or maintained by the Company. The Medicare plan that you select and that is paid for by this Plan, if any, is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Customer Service

Overview

Claims Administrator	Mercer 1-855-429-8812, PO Box 424 Escondido, CA 9203350306
COBRA and Direct Bill Questions	COBRA administrator
General Human Resources Questions	Human Resources Department, New Castle Stainless Plate, LLC P.O. Box 370 New Castle, IN 47362 765-529-0120

Eligibility

Retiree Eligibility

A retiree who is eligible for the Plan is an "Eligible Retiree." An Eligible Retiree who becomes covered under the Plan is a "Participant."

You are eligible to participate in the Plan only if you satisfy the following requirements (and any applicable rule set out below):

1. You are 65 or older and are eligible for Medicare;
2. You enroll in an individual medical plan through Mercer Marketplace 365+ Retiree;
3. You are classified by the Company as "retired" from the Company or from a predecessor Company;
4. You were, at the time of retirement, covered by the collective bargaining agreement between the Company and the UAW Local 729 Bargaining Unit;
5. You were hired prior to January 18, 2016 and/or were hired from the rehire list as reflected in the CBA;
6. You were hired on or after January 18, 2016, have at least 20 years of service, and would otherwise meet the age and service requirements applicable to those eligible for early or normal retirement under the New Castle Stainless Plate, Inc. Wage Retirement Income Plan for Members of UAW Local 729.

Ineligible Retirees

Regardless if you otherwise satisfy the eligibility rules above, you are not eligible to participate in the Plan if you, as an employee, were classified or treated by the Company as:

- Subject to a collective bargaining agreement unless and to the extent that the agreement provides for your participation;
- A temporary employee or a project employee;
- A person who is not a common law employee (including without limitation a leased employee, independent contractor, contingent worker, service worker, consultant, contract worker, agency worker or freelance worker), regardless of your actual legal status or whether you are later determined to be a common law employee;
- A person who retired from a Company affiliate that was not a Participating Employer at the time of his or her retirement;
- Covered by a contract or other written agreement that provides you are not eligible for the Plan; or
- A person who was not covered not a member of the UAW Local 729 Bargaining Unit.

COBRA Enrollees in the Active Employee Medical Plan

Retirees who elect not to enroll in the Plan at the time of their retirement and elect to continue coverage under an active employee medical plan sponsored by the Company through COBRA shall not be eligible to participate in the Plan and cannot enroll in the Plan at a later date, even after COBRA ends. Any Eligible Dependent who elects not to enroll in the Plan at the time of the retiree's retirement and elects to continue coverage under an active employee medical plan sponsored by the Company through COBRA shall not be eligible to participate in the Plan and cannot enroll in the Plan at a later date, even after COBRA ends. Such Eligible Dependent's election not to enroll in the Plan does not impact the retiree's eligibility for the Plan.

Classification

The classification of an individual by the Company is conclusive and binding for purposes of determining eligibility to participate in this Plan and shall be made solely in the discretion of the Company. No reclassification or determination of a person's status with the Company, for any reason, without regard to whether it is initiated by a court, governmental agency or otherwise and without regard to whether or not the Company agrees to such reclassification or determination, shall make the person retroactively or prospectively eligible for benefits. However, the Company, in its sole discretion, may reclassify a person as benefits eligible on a prospective basis. Any uncertainty regarding an individual's classification will be resolved by excluding the person from eligibility.

Spouse/Domestic Partner Eligibility

If you are covered under the Plan as an Eligible Retiree, your Eligible Spouse or Domestic Partner may be covered to the extent provided by the Plan. A Spouse or Domestic Partner who is eligible for the Plan is an "Eligible Dependent." An Eligible Dependent who becomes covered under the Plan is a "Covered Dependent."

Your spouse or domestic partner is eligible to participate in the Plan only if your spouse/domestic partner satisfies the following requirements (and any applicable rule set out below):

- You are a retiree who is eligible to be covered, or who is covered, under the Plan;
- You and your dependent are eligible to participate in the Plan at the time of your retirement;
- Your dependent is age 65 and eligible for Medicare; and
- Your spouse or domestic partner enrolls in an individual medical plan through Mercer Marketplace 365+ Retiree;
- Your dependent satisfies the applicable eligibility requirements for a "spouse," or "domestic partner" as set forth below.

Eligible Spouse

A spouse is eligible only if the spouse is your legally married (including a common law marriage) same sex or opposite sex spouse at the time of your retirement. Upon divorce or legal separation, a spouse ceases to be eligible for coverage regardless of whether the divorce decree or court order requires you to provide coverage to your former spouse.

Eligible Domestic Partners

Your domestic partner is eligible only if:

- You are in a single dedicated relationship of at least 12 months' duration with the intention of remaining in the relationship indefinitely;
- You have co-habited a permanent residence for the previous 12 months with the intention of continuing co-habitation;
- You are unrelated by blood to a degree of closeness that would prohibit marriage in the law of the state in which you reside;
- You are each at least 18 years old;
- You are both mentally competent to consent to contract;

- Neither of you is currently married to another person under either statutory or common law;
- You share joint financial responsibility for basic living expenses including food, shelter, medical expenses; and
- You are financially interdependent and have provided the Company with at least four of the following documents evidencing such financial interdependence:
    - joint ownership of real property or a common leasehold interest in real property;
    - evidence of a joint mortgage or lease;
    - joint bank account;
    - joint credit account;
    - joint obligation on a loan;
    - evidence of common household expenses e.g. utility, telephone bills;
    - a will which designates the other as primary beneficiary;
    - granting each other durable powers of attorney;
    - granting each other health care powers of attorney;
    - a beneficiary designation form for a retirement plan or life insurance policy signed and completed to the effect that one domestic partner is the primary beneficiary of the other; or
    - proof of domestic partner registration, if the domestic partners reside in a state which provides for such registration.

Tax Consequences of Domestic Partner Benefits

Unless your domestic partner is considered your federal tax dependent under the Internal Revenue Code for health benefit purposes as described below, the Internal Revenue Service currently treats as imputed income to you the value of the coverage provided for your domestic partner. In general, a domestic partner who is a member of your household qualifies as your tax dependent for health benefit purposes if:

- He or she receives more than 50% of his or her financial support from you;
- He or she lives with you (shares a personal residence) for the full tax year (except for temporary reasons such as vacation, military service or education);
- He or she is a citizen, national or legal resident of the United States; or a resident of Canada or Mexico; or is a child being adopted by a US citizen or national;
- He or she is not a section 152 qualifying child dependent on another taxpayer's filed return or is a section 152 qualifying child dependent on another taxpayer's return where the filing is only to obtain a refund of withheld income taxes; and
- Your relationship is not in violation of any local laws.

You are advised to consult with your tax advisor to determine if your domestic partner is your federal tax dependent and to review the tax consequences of electing domestic partner benefit coverage.

In general, state income tax treatment of domestic partner benefits is the same as the federal income tax treatment. However, certain benefits for domestic partners who are not your federal tax dependents may be eligible for special state income tax treatment in a few select states. Please speak to your tax advisor regarding whether your domestic partner qualifies for the special state income tax treatment.

Evidence of Eligibility

You may be asked to provide evidence substantiating dependent status of an individual you wish to cover. Failure to provide such proof to the satisfaction of the Company will result in denial or termination of coverage. In the event your enrolled dependent becomes ineligible for the Plan, you must notify the Company within 31 days of the event resulting in ineligibility.

New Dependents

A dependent is eligible for coverage under this Plan only if the dependent was your Eligible Dependent at the time of your retirement. A spouse or domestic partner who was not eligible at the time of your retirement is not eligible to participate in the Plan.

Consequences of Coverage of Ineligible Individuals

The following are a violation of Company policy and are considered fraud under the terms of this Plan:

- Covering ineligible individuals under the Plan, such as covering an ineligible individual as your dependent or failing to notify the Claims Administrator that a dependent has ceased to be eligible; or
- Making a misrepresentation regarding the basis for Plan coverage.

The Plan reserves the right to cancel coverage and deny claim payments retroactively as well as recover any and all benefit payments made on behalf of an ineligible individual. In addition, the Company reserves the right to take disciplinary action, up to and including:

- Termination from the Plan of the Covered Retiree and any Covered Dependents; and
- All other civil and criminal recourse, for such actions.

Participating in the Plan

Overview

An eligible retiree, spouse or domestic partner becomes a participant in the Plan on the later of (1) January 1, 2022, or (2) the first day of the month the individual's medical policy purchased through Mercer Marketplace is effective.

When Coverage Ends

Overview

Coverage for you will end upon any of the following:

- You no longer meet the eligibility requirements for the Plan;
- You are no longer covered by an individual medical policy through Mercer Marketplace
- There are no remaining amounts credited to the Reimbursement Account and the balance in the account is zero and there will not be any future HRA allocations;
- Your retiree status ends;
- The Plan is terminated or amended such that you are no longer eligible for coverage;
- You elect to end or suspend coverage;
- Your death;
- You attempt to obtain benefits fraudulently for yourself or others (such as requesting reimbursement for an ineligible dependent); or
- You fail to follow the Plan's procedures or violate the terms of the Plan as determined by the Plan Administrator.

Coverage for your Covered Dependents will end upon any of the following:

- You become divorced or legally separated;
- The Plan is terminated or amended such that your Covered Dependent is no longer eligible for coverage;
- Your Covered Dependent no longer meets the eligibility requirements;
- Your Covered Dependent elects to end or suspend coverage;
- Your Covered Dependent's death;
- Your Covered Dependent attempts to obtain benefits fraudulently for himself/herself or others; or
- Your Covered Dependent fails to follow the Plan's procedures or violates the terms of the Plan as determined by the Plan Administrator.

If your surviving spouse remarries after your death, your surviving spouse's coverage will end.

If your spouse/domestic partner cease to satisfy the eligibility requirements, contact the Claims Administrator. In most events, coverage ends on the last day of the month that the dependent no longer meets the dependent eligibility requirements.

No future HRA Credits will be allocated to your account once coverage ends.

No future HRA Credits will be allocated to the Reimbursement Account for your Covered Spouse or Domestic Partner once coverage ends for the individual.

Rules for Surviving Spouses [and Domestic Partners?]

Upon the death of a Participant, Participant shall cease. Any Surviving Spouse may continue to use any balance available in the Reimbursement Account and will receive future allocations as long as participation requirements are met.

If there is no surviving spouse upon the death of a Participant, any HRA Credits in the Reimbursement Account will be forfeited after the deadline to submit claims for the deceased.

Rule for Divorced or Legally Separated Spouses

If you become divorced or legally separated from your spouse, allocations for your ex-spouse will end upon the date of divorce or legal separation. Your ex-spouse may be eligible for COBRA continuation coverage. You must notify the Company of a divorce or legal separation, and your notice must include a copy of the decree of divorce or legal separation.

Reimbursement Account

Overview

A “Reimbursement Account” will be established for a Participant and his or her Covered Dependent(s), if any, at the time the Eligible Retiree becomes a Participant in the Plan. A Participant and his or her Covered Dependent(s), if any, will share one Reimbursement Account.

Crediting of Accounts

Each Plan Year you are eligible, the Reimbursement Account will be credited with a specified “HRA Allocation” pursuant to Plan rules that can be used for reimbursement of Eligible If you have Covered Spouse or Domestic Partner, you will be credited with a specified “HRA Allocation” pursuant to Plan rules.

If an Eligible Dependent becomes covered under the Plan prior to you becoming covered under the Plan, If you cease to be a Participant in the Plan for any reason, both Participant and Dependent Allocations (if any) shall end, subject to any COBRA rights that may exist. Dependent Allocations will end upon the last Covered Dependent ceasing to be covered under the Plan, subject to any COBRA rights that may exist.

The amount of HRA Credits allocated to your Reimbursement Account is described in the Appendices, subject to the rules below. HRA Credits are pro-rated for the year in which the Reimbursement Account is established.

The HRA Allocation to your Reimbursement Account is described in the Appendices, subject to the rules below. HRA Allocations are pro-rated for the year in which the Reimbursement Account is established.

The Reimbursement Account is simply a bookkeeping entry, meaning that the HRA Credits do not represent actual contributions made on behalf of a Participant or Covered Dependent and funds are not deposited into any separate account on behalf of a Participant or Covered Dependent.

Neither a Participant nor any Covered Dependent(s) are able to contribute to the Reimbursement Account. A Covered Dependent may, however, be required to pay the “applicable premium” for

continuation of Plan coverage under COBRA. See “General Notice of COBRA Continuation Coverage” section for more information regarding COBRA continuation coverage.

Reimbursements

During the Plan Year, the Reimbursement Account balance will be reduced by any amount paid to you, or for your benefit, for eligible expenses incurred by you or your eligible spouse/domestic partner. Your spouse/domestic partner must be an active participant in the Plan to have eligible expenses under this Plan. The amount available for reimbursement of eligible 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.

Amounts credited to the Reimbursement Account can only be used for reimbursement of Eligible Expenses incurred by the Participant or Covered Dependent. Any HRA account balance that is not used during a Plan Year in accordance with the Plan remain available in the next Plan Year provided you and/or your Covered Dependent are still a participant in the Plan.

Eligible Expenses for Reimbursement

Overview

You may use your HRA for reimbursement of certain eligible expenses, provided the expense:

- Has been incurred by the Participant or an Eligible Spouse or Domestic Partner, as described on pages 4-5;
- Is not reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement;
- Does not exceed your HRA account balance;
- Is incurred while you are participating in the HRA; and
- Is considered to be tax-deductible under Internal Revenue Code Section 213 and defined as an eligible expense by the Plan Sponsor.

The following expenses incurred by a Participant or Covered Dependent are eligible for reimbursement under the Plan (provided all other terms and conditions of the Plan have been satisfied):

- Individual health insurance premiums;
- Prescription Drug premiums, including income-related monthly adjustment (IRMAA) on Prescription Drug premiums, if applicable;
- Dental insurance premiums;
- Vision insurance premiums;
- Medicare Part B premiums, including income-related monthly adjustment (IRMAA) on Medicare Part B premiums, if applicable;
- Out-of-pocket expenses that are allowed to be reimbursed under Internal Revenue Code Section 213(d) (e.g. deductibles, copays, coinsurance, and other health related expenses allowable under Internal Revenue Code Section 213(d));
- Premiums under another employer-sponsored group health plan that are paid on an after-tax basis;
- Health care expenses associated with other coverage, including Medicaid, TRICARE, and CHAMPVA; and
- “Over-the-counter” (OTC) drugs obtained without a doctor’s prescription and menstrual care products.

Please note, if you are submitting reimbursement for prescription drug co-payments, co-insurance or deductibles, you must report these reimbursements to your Medicare Part D provider. Failure to report reimbursement of prescription drug co-payments, co-insurance or deductibles to your Medicare Part D provider could result in your Medicare Part D provider terminating your coverage.

An expense that is eligible for reimbursement under the Plan is referred to as an “Eligible Expense”.

Ineligible Expenses

An expense that is not an Eligible Expense is not eligible for reimbursement. Ineligible expenses include but are not limited to the following:

- Any expenses incurred for qualified long term care services;

- Expenses incurred prior to the date that coverage under the Plan becomes effective (but excluding payments for premiums listed above for health care coverage that begins on or after coverage under the Plan becomes effective);
- Expenses incurred after the date that coverage under the Plan ends;
- Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan;
- Expenses paid pre-tax; and
- Premiums for fixed indemnity policies, disease specific fixed indemnity policies (such as a cancer fixed indemnity policy), hospital indemnity insurance policies, travel and accident policies, life insurance policies, income protection policies, disability policies, and health care sharing programs or health care sharing ministries.

"Incurred" means the date the service or treatment is provided, not when the expense arising from the service or treatment is paid. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

Additionally, expenses incurred by individuals who are not a Participant or Covered Dependent are ineligible for reimbursement.

HRA Credits

Rule for Surviving Spouses and Dependents

Upon the death of a Participant, Participant shall cease. Any Surviving Spouse may continue to use any balance available in the Reimbursement Account and will receive future allocations as long as participation requirements are met.

If there is no surviving spouse upon the death of a Participant, any HRA balance in the Reimbursement Account will be forfeited after the deadline to submit claims for the deceased.

Rule for Death of Eligible Dependent

Upon the death of an Eligible Spouse or Domestic Partner, any HRA account balance remaining in the Reimbursement Account will remain available to the Participant. If the Participant is also deceased, all HRA Credits remaining in the Reimbursement Account will be forfeited following the 90-day claim submission deadline described in the “Claims Procedures” section below.

HRA Allocations

The Plan Administrator reserves the right to change retroactively or prospectively how the HRA Allocations have been calculated and credited to a Reimbursement Account. This right includes reducing or eliminating any HRA Allocations that have been credited to a Reimbursement Account. Individuals do not have a vested right to HRA Credits. The Plan Administrator’s calculation of HRA credits is final and conclusive.

HRA Allocations are notional arrangements, meaning that the HRA Allocations do not represent actual contributions made on your behalf and funds are not deposited into any separate account on your or your dependent’s behalf. The Company reserves the right to reduce or eliminate HRA Allocations, both prior to or after an individual becomes covered under the Plan. Individuals do not have a vested right to HRA Credits. An eligible participant who did not become covered under this Plan at the time of initial eligibility, forfeits any HRA Allocations that the employee or eligible dependents may have otherwise been eligible to receive. An employee or eligible dependent may have requested or received a projection of HRA Allocation prior to the employee’s actual retirement, but there is no guarantee that the individual will actually be eligible or receive such HRA Allocations and receiving such projection does not entitle an individual to HRA Allocations generally or the amount of HRA Allocations specified in the projection. The Company reserves the right to determine and change the HRA Allocations.

Claims Procedures

Requesting Reimbursement from your HRA Account

When you incur eligible health care expenses, you may submit a request for reimbursement from your HRA account. Below is a summary of the reimbursement process.

Requesting reimbursement

When you enroll in coverage through Mercer Marketplace, you pay the premium to your insurance carrier(s) and pay your health care expenses, such as copays and deductibles, as they are incurred. You are responsible for maintaining documentation of your payments and receipts, and will be required to provide required documentation with your reimbursement request submission.

Some participating insurers enable an Automatic Premium Reimbursement. When the option is available and if you have opted in to this method of reimbursement during a call with the Mercer Marketplace benefits counselor, after you pay your premium, the insurance carrier provides Mercer Marketplace with documentation of your premium payment and Mercer Marketplace will reimburse you for the eligible premium expense until the HRA funds are depleted.

If you do not opt in or otherwise cannot utilize the Automatic Premium Reimbursement option, you may submit a claim for eligible expenses to be reimbursed from your HRA account using either a Recurring Reimbursement for premiums or a One-Time Reimbursement for out-of-pocket expenses or premiums.

If you do not opt in or otherwise cannot utilize the Automatic Premium Reimbursement option, to be reimbursed for eligible expenses, you must complete a reimbursement request online through the HRA account portal or on paper by mail or fax and provide the required documentation to substantiate the claim. Required documentation includes:

For Out-Of-Pocket Expenses:

- Covered Participant Name (i.e., retiree, spouse, or domestic partner)
- Provider Name
- Date of Service
- Expense Type (e.g. Medical premium, office visit co-pay)
- Proof of Expense Amount (e.g. invoice or receipt from provider that identifies the participant name and service date and description, an Explanation of Benefits from insurer that identifies amount owed by participant); all pages of an Explanation of Benefits must accompany a prescription drug expense to verify the phase of Medicare Part D.

For Premium Expenses:

- Covered Participant Name (i.e., retiree, spouse, or domestic partner)
- Insurer Name
- Premium Type (e.g. medical)
- Date of Coverage (e.g. 01/01/20xx–12/31/20xx)

- Premium amount (e.g. statement or invoice from insurer)

Claims for out-of-pocket expenses can be submitted as incurred and reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator (as identified below).

Claims may be submitted directly through the website portal, faxed or sent through the mail to the appropriate contact information listed below. The individual account holder must sign his or her own form or submit his or her own claim via the website portal.

All claims for a Plan Year must be submitted to the Claims Administrator by March 31 following the end of the year in which such claim was incurred. Any claims for reimbursement post-marked after that date will not be considered for reimbursement by the Claims Administrator, even if there are funds in your HRA Account.

The Claims Administrator for the HRA Account is Mercer Marketplace 365+ Retiree.

You may contact the Claims Administrator by phone at 855-429-8812 (for the deaf or hard of hearing, please dial 711 for Telecommunications Relay) or in writing at:

Mercer Marketplace Claims Department
PO Box 424
Escondido, CA 92033

COBRA

Under federal law, eligible dependents may lose coverage due to a COBRA qualifying event such as a divorce or death.

Eligible dependents are required to notify the Plan Administrator in writing of a qualifying event within 60 days of the event or they will lose the right to continue coverage under the HRA. If an eligible dependent elects to continue coverage, he/she is entitled to the level of coverage the HRA in effect immediately preceding the qualifying event.

In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of the qualifying event.

Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary's HRA is exhausted;
- The date the qualified beneficiary notifies the Plan Administrator that he/she wishes to discontinue coverage;
- Any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the qualified beneficiary's election to continue coverage, that he/she becomes covered under another group health plan; or
- The employer ceases to provide any group health plan.

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your and your family members' addresses. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Claims Denials and Appeals

Filing a Claim

You must file a claim for reimbursement in accordance with the Plan's procedures and requirements, as described in the HRA Reimbursement Guide or as provided by the HRA Claims Administrator. In general, any participant or beneficiary under the HRA may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the HRA Claims Administrator. When the HRA Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the HRA.

You may designate an authorized representative to handle the claim, or any subsequent appeal, on your behalf. To designate an authorized representative to act on a participant's or beneficiary's behalf with respect to a benefit claim, you (or your spouse) must submit a written request on a form approved by the HRA Claims Administrator, which the participant or beneficiary signs and which authorizes the representative to act on their behalf with respect to the benefit claim. If a party is not properly designated as an authorized representative under the HRA, the HRA Claims Administrator will not communicate with that party with respect to any benefit claim or other exercise of a participant's or beneficiary's rights under the HRA. The HRA will also recognize a court order giving a person authority to submit claims on a Participant's or beneficiary's behalf. Any attempted assignment of benefits by a Participant or beneficiary to a health care provider is void, and does not constitute a designation of an authorized representative for purposes of the HRA.

Claims Administrators – Self-Insured Plan Benefits

The HRA benefits listed below are self-insured. The Company has the fiduciary responsibility for determining whether you are entitled to benefits and authorizing payment. Benefits are paid out of the general assets of the Company and are not guaranteed under a contract or policy of insurance.

HRA Claims Administrator	Mercer Marketplace Claims Department PO Box 424 Escondido, CA 92033 855.429.8812 http://retiree.mercermarketplace.com/NCSP

This section provides general information about the claims and appeals procedure applicable to certain HRA benefits under ERISA. **If there are any discrepancies between the claims and appeals procedures in this summary and the applicable plan document, this summary will govern.**

Claim-Related Definitions

Claim

"Claim" is any request for plan benefits made in accordance with the HRA's claims-filing procedures, including any request for a service that must be pre-approved.

Claims for benefits under the HRA are considered "Post-service claims", meaning they are claims involving the payment or reimbursement of costs for health care that has already been provided.

Adverse Benefit Determination

If the Claims Administrator does not fully agree with your claim, you will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the HRA.

- An expense being ineligible under the provisions of the HRA.

An adverse benefit determination for benefit claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the HRA, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time.

Initial Claim Determination

For HRA benefits, the Claims Administrator has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Claims Administrator has to evaluate and respond to a claim begins on the date the Claims Administrator receives the claim. If you have any questions regarding how to file or appeal a claim, contact the HRA Claims Administrator. The timeframes on the following pages apply to the various types of claims that you may make under the HRA, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the HRA's review procedures and the time limits applicable to such procedures; and
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review; and
- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request.

Time Frames for Initial Claims Decisions

Time frames generally start when the Claims Administrator receives a claim. Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days. HRA claims are considered non-urgent "post-service" claims.

	Claims Administrator
	Non-Urgent "Post-Service" Claims
Time for Providing Notice	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.
Extensions	The Claims Administrator has up to 15 days, if necessary due to matters beyond the Claims Administrator's control, and must provide extension notice before the initial 30-day period ends.*
Period for Claimant to Complete Claim	You have at least 45 days to provide any missing information.
Other Related Notices	N/A

	Claims Administrator
	Non-Urgent “Post-Service” Claims

* 15 day extension period is measured from the time that the claimant responds to the notice from the Claims Administrator that the claim is missing information.

Appealing a Claim

First-Level Mandatory Appeal

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing and should be filed with the HRA Claims Administrator as listed in the *Filing a Claim* section of this SPD. If you don’t appeal on time, you lose your right to later object to the decision. You may not proceed to the Second-Level Voluntary Appeal without completing a First-Level Mandatory Appeal.

The review will be conducted by the HRA Claims Administrator, or other appropriate named fiduciary of the HRA, depending on the subject of the review. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The HRA Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The HRA Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits.

Prior to making a benefit determination on review, the HRA Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the HRA (or at the direction of the Plan Administrator) in connection with the claim. If applicable, this evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final first-level internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

The HRA Claims Administrator will provide you with written notification of the determination on review, within the time frames described in the *Time Frames for Appeals Process* section of this SPD. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the HRA on which the determination is based;
- A statement that you are 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 for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review;
- A description of the voluntary appeals procedure under the HRA, and your right to obtain additional information upon request about such procedures; and
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request.

Time Frames for Appeals Process

The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the HRA's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. References to "days" mean calendar days. The HRA can require two levels of mandatory appeal review.

Period for Filing Appeal	You have at least 180 days.
Time frame for Providing Notice of Benefit Determination on Review	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.
Extensions	None

Second-Level Voluntary Appeal

If you receive notice of an adverse notice of benefit determination on review for your first-level appeal, and disagree with the decision, you are entitled to apply for a final voluntary second-level appeal. You (or an appointed representative) can request a second-level review within 30-days of the notice of benefit determination on review from your first-level appeal. The request must be made in writing and should be filed with the Plan Administrator (not the HRA Claims Administrator). If you don't appeal on time, you lose your right to later object to the decision. You may not proceed to the Second-Level Voluntary Appeal without completing a First-Level Mandatory Appeal.

The second-level review will be conducted by the Plan Administrator and any additional appropriate named fiduciaries of the HRA, depending on the subject of the review. For more information regarding the final voluntary appeal, please contact the Plan Administrator.

The final voluntary appeal should include any new information pertinent to the claim.

You will receive a written notification within 15 days after your request was received as to whether the information is considered new information.

If it is determined that there is no new information pertinent to your claim, you will be notified in writing that your final appeal will not be considered. If it is determined that there is new information, a decision will be made within 60 days of the date the Plan Administrator receives the voluntary appeal.

If the Plan Sponsor fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your benefit claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan Sponsor action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan Sponsor's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan Sponsor to explain why the error is minor and why it meets this exception.

Unless the right to an external review applies under the benefit plan, all decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

External Review
For benefits, you may have the right to request an external review of a claim involving medical judgment, as determined by the external reviewer, or a coverage rescission. You must request the external review within four (4) months of the date you receive an adverse benefit determination. If your request for an external review is determined eligible for such a review, an independent organization will review the HRA Claims Administrator's decision and provide you with a written determination.

The external review decision is binding on you and the Plan Sponsor, except to the extent other remedies are available under federal law.

The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that is not related to medical judgment or coverage rescission.

General Rules

Any claim, appeal or request must be made in writing. Oral inquiries are not considered claims, appeals or requests.

All time periods described are in calendar days.

Your Rights

Exhaustion of Administrative Remedies

You must exhaust the entire claims procedure prior to bringing a civil action to recover benefits, enforce or clarify your rights under the Plan.

Deadline to Commence a Lawsuit

If you file your claim within the required time, you complete the entire claims procedure, and your appeal is denied, you may sue over your claim (unless you have executed a release of your claim). You must, however, commence that suit within the earlier of:

- Two years after you knew or reasonably should have known of the facts behind your claim; or
- Ninety days after the claims procedure is complete.

Coordination of Benefits

Overview

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Expenses (to the extent all other conditions for Eligible Expenses have been satisfied). As such, the Plan does not coordinate benefits with any other group or individual health coverage except as provided herein.

Suspending Your Coverage

Overview

Your coverage in this Plan will be suspended if you are a Participant who is rehired by the Company or an affiliate as an employee. Your Reimbursement Account will be suspended on the date that you return to active employment and you will not be considered a Participant in this Plan during active employment. When your coverage is suspended, neither you nor your Covered Dependents will be entitled to reimbursement of any claims under the Plan.

When the circumstance described above ends, a Participant may request that the Account be actively resumed by contacting the Claims Administrator. However, expenses incurred during the period that the Account is suspended will be ineligible for reimbursement, even after the Account is no longer suspended and even if such expenses are otherwise Eligible Expenses.

Continuing Your Coverage

General Notice of COBRA Continuation Coverage

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), created the right to continue health coverage. COBRA continuation coverage is a temporary extension of coverage under a group health plan after you or your family loses coverage in certain circumstances. This "Continuing Your Coverage" section:

- Contains important information about your right to COBRA continuation coverage;
- Explains when COBRA coverage may become available; and
- Describes what you need to do to protect your right to receive COBRA coverage.

For additional information about your rights and obligations under the Plan and under federal law, contact the COBRA Administrator.

COBRA Eligibility – COBRA Qualified Beneficiaries

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". After a qualifying event (and any required notice of that event is properly provided), COBRA continuation coverage must be offered to each "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if you are covered under the Plan on the day before the qualifying event and that coverage is lost because of a qualifying event. As discussed below, there is one circumstance in which you could be a qualified beneficiary as well. Qualified beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation period.

The Plan offers COBRA continuation coverage to qualified beneficiaries only after the Company is notified that a qualifying event has occurred. Qualified beneficiaries who elect COBRA continuation coverage must pay for it on an after-tax basis.

COBRA Qualified Beneficiaries

Your spouse becomes a COBRA qualified beneficiary if you are covered under the Plan and he or she loses coverage under the Plan because of any of the following qualifying event:

- You become divorced or legally separated from your spouse.

Also, if you eliminate coverage for your spouse in anticipation of a divorce or legal separation, your ex-spouse may still be entitled to COBRA continuation coverage even though he or she lost coverage before the divorce or legal separation. It is therefore important for your ex-spouse to notify the Company of the divorce or legal separation even if coverage had been eliminated earlier. Your ex-spouse should follow the procedures outlined under the "Notification of Qualifying Events" topic under this section for providing such notice.

Under COBRA, if you are a retiree, you can only become a qualified beneficiary in the very unlikely event that the Company files for a proceeding in bankruptcy under Title 11 of the United States Code. If a proceeding in bankruptcy were filed, and if you and/or any family members lose coverage within one year before or after, and as a result of, the bankruptcy filing, you, your spouse and your dependents will become qualified beneficiaries.

Notification of Qualifying Events

You or your qualified beneficiaries **must notify the Company** of certain qualifying events. These events include your death; your divorce or legal separation and your dependent child's loss of eligibility for coverage because he or she is no longer a dependent child. The Plan offers COBRA continuation coverage to qualified beneficiaries only after the Company is notified that a qualifying event has occurred. To notify the Company, call the COBRA Administrator within 60 days after the later of the:

- Date the qualifying event occurs; or
- Date your spouse or your dependent loses (or would lose) coverage on account of the qualifying event.

The 60-day period is extended to the next business day if the last day of the 60-day election period falls on a Saturday, Sunday, or legal holiday. When you call, you are asked to furnish:

- Your name;
- The names of all qualified beneficiaries affected by the event;
- The qualifying event that has occurred (you may be required to submit additional evidence of the qualifying event);
- The date of the qualifying event; and
- Your address and the addresses of any qualified beneficiaries who do not live with you.

If you are not a retiree, notify the Company of the qualifying event in writing by completing a Qualified Beneficiary Notice Form (contact the COBRA Administrator to request a form).

If mailed, the Qualified Beneficiary Notice Form must be postmarked no later than the deadlines described above. If faxed, the Qualified Beneficiary Notice Form must be sent by the deadlines described above. To complete the Qualified Beneficiary Notice Form furnish:

- Your name;
- The names of all qualified beneficiaries affected by the event;
- The qualifying event that has occurred (you may be required to submit additional evidence of the qualifying event);
- The date of the qualifying event; and
- Your address and the addresses of any qualified beneficiaries who do not live with you.

If you are notifying the Company of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

You must provide notice in a timely manner. If you, your spouse or your dependent fails to provide notice in the manner outlined above during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.

Electing COBRA Coverage

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Retirees may elect COBRA continuation coverage on behalf of his or her spouse. It is critical that you (or anyone who may become a qualified beneficiary) maintain a current address with the COBRA Administrator to ensure that you receive a COBRA enrollment notice following a qualifying event.

You (and any qualified beneficiary) have 60 days after the date of the COBRA election notice (or, if later, 60 days after the date coverage is lost) to decide whether to elect COBRA under the Plan. For each qualified beneficiary who timely elects COBRA continuation coverage, COBRA continuation coverage begins on the date coverage under the Plan would otherwise end.

How to Elect COBRA Continuation Coverage

After proper and timely notice of a qualifying event, you will be sent a COBRA Enrollment Notice. To elect COBRA continuation coverage, you, your spouse or your dependents must complete the enrollment election by calling the COBRA Administrator within 60 days from the date of the COBRA Enrollment Notice (or, if later, the date coverage is lost) according to the directions on the form.

If you (on behalf of your spouse or dependents) or your spouse and dependent children do not elect continuation coverage within this period, your spouse and/or dependents will not receive continuation coverage. If mailed, your enrollment election must be postmarked no later than the last day of the 60-day election period or no later than the date on the election form.

How Long COBRA Continuation Coverage Lasts

COBRA continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is:

- Your divorce or legal separation; or

Cost of Continuation Coverage

COBRA participants must pay monthly premiums for coverage. Each qualified beneficiary will be required to pay the entire cost of COBRA continuation coverage plus 2% for administrative costs. The amount of COBRA premiums can be increased from time to time during your period of COBRA coverage to the extent permitted by federal law.

Paying for COBRA Continuation Coverage

Qualified beneficiaries will not be considered to have made any COBRA payment if their check is returned due to insufficient funds or otherwise.

First Payment for COBRA Continuation Coverage

If COBRA continuation coverage is elected, no payment has to be sent at the time of the enrollment election. However, the first payment for COBRA continuation coverage must be made no later than 45 days after the date of election. (This is the date the enrollment election is postmarked, if mailed.)

If the first payment for COBRA continuation coverage is not made in full within 45 days after the COBRA election date, all COBRA continuation rights under the Plan are lost. Qualified beneficiaries are responsible for making sure that the first payment's amount is correct. Call the COBRA Administrator to confirm the correct payment amount.

At the time of election, qualified beneficiaries will be told where to send the first payment.

Ongoing Payments for COBRA Continuation Coverage

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example, June payment is due June 1, but is accepted if postmarked by June 30).

COBRA continuation coverage is provided for each month, as long as payment for that month is made before the end of the grace period for that payment. If mailed, COBRA payment must be postmarked on or before the end of the grace period.

If ongoing payments are not made before the end of the grace period, all rights to COBRA continuation coverage under the Plan are lost. If COBRA continuation coverage is cancelled for nonpayment, coverage will not be reinstated, and you will have no further rights to COBRA continuation coverage.

When COBRA Coverage Ends

COBRA coverage ends before the maximum continuation period if one of the following occurs:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered under another health plan not offered by the Company;
- After electing COBRA continuation coverage, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both); or
- The Company stops providing health benefits to any employee.

COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

Notify the COBRA Administrator immediately if a qualified beneficiary becomes covered under another group health plan or enrolls in Medicare.

Keep Your Plan Informed of Address Changes

In order to protect you and your family's rights, you and/or your family members should keep the COBRA Administrator informed of any changes in your address and the addresses. You and/or your family members should also keep a copy of any notices sent to the COBRA Administrator.

Employee Retirement Income Security Act (ERISA) Statement of Rights

About Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants will be entitled to the information as described in this section.

Receive Information About Your Plan and Benefits

ERISA provides that all Plan Participants will be entitled to:

- Examine without charge, at the Plan Administrator's office and at other specified locations, such as work sites 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 (EBSA) at:

  Public Disclosure Room
  Employee Benefits Security Administration
  U.S. Department of Labor
  200 Constitution Avenue, N.W., Room N 15
  Washington, D.C. 20210
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (SPD). 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.

Prudent Actions by Plan Fiduciaries

In addition to creating certain rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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 which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's appeal procedure.
- In addition, if you should disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.
- If it should happen that the 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.
- If you file suit against the Plan, 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 that your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, 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, contact the nearest office of the Employee Benefits Security Administration (EBSA), 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 Northwest
Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the publications hotline of the EBSA at (866) 444-3272;
- Logging on to the Internet at **dol.gov/ebsa**; or
- Contacting the EBSA field office nearest you.

Important Plan Information

Plan Administrator

The Plan Administrator shall have the discretionary power and authority to:

- Control and manage the operation of the Plan;
- Prescribe applicable Plan procedures;
- Make all decisions and determinations with respect to the Plan: and
- Interpret and apply the terms of the Plan.

This discretionary power and authority includes, without limitation:

- Determining all factual and legal questions;
- Interpreting any ambiguous or unclear terms in the Plan and the underlying documents;
- Deciding eligibility for coverage and eligibility for benefits; and
- Establishing rules to carry out administration of the Plan.

All determinations, interpretations, rules and decisions of the Plan Administrator will be made, in its sole discretion, and will be final, conclusive and binding as to all parties. In any legal action, all explicit and all implicit determinations by the Plan Administrator shall be afforded the maximum deference permitted by law. The Plan Administrator may delegate all or a portion of its powers, authority, responsibilities, discretion and rights under the Plan to an individual, entity or committee. Any delegation may, if specifically stated, allow further delegation by the individual, entity or committee to whom the delegation has been made.

The Plan Administrator reserves the right to correct any errors, defects, inconsistencies and omissions that may occur in the administration of the Plan as the Plan Administrator, in its discretion, determines appropriate. This includes reducing or eliminating benefits under the Plan, and such correction shall be final and binding all persons. Subject to any delegation of authority, the Plan Administrator shall be the named fiduciary for the purposes of ERISA.

Claims Administrator

The Plan Administrator has contracted with the Claims Administrator to assist in the handling of benefit determinations under the Plan and to provide assistance in the administration of the Plan. The Claims Administrator has:

- The authority to make benefit determination under the Plan;
- Direct payments with respect to the Plan, and
- Such other responsibility and authority as delegated by the Plan Administrator.

Benefit Determinations

The Plan Administrator delegates its full and final discretionary power and authority with respect to benefit determinations to the Claims Administrator. This power and authority includes, without limitation:

- Determining all factual and legal questions;
- Interpreting any ambiguous or unclear terms in the Plan and the underlying documents;
- Determining the amount of benefits, if any, to which an individual is entitled to under the Plan;
- Deciding the manner and terms of payment;
- Prescribing forms to be used and procedures to be followed in applying for benefits and appealing any adverse benefit decision under the Plan; and
- Deciding all claims for benefits, adverse benefit determinations and appeals.

The Claims Administrator has discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan shall only be paid if the Claims Administrator decides, in its discretion, that an individual is entitled to them. With respect to benefit determinations, all determinations, interpretations, rules and decisions of the Claims Administrator shall be final, conclusive and binding as to all parties. This delegation of authority shall not, however, apply to determinations pertaining to eligibility to participate in the Plan, which shall remain with the Plan Administrator. With respect to its delegated authority, the Claims Administrator is a named fiduciary under the Plan.

Amendment or Termination

The Company reserves the right to amend and terminate the Plan in whole or in part, at any time and in any respect and for any reason and either prospectively or retroactively or both. The Company's right to amend or terminate the Plan includes, without limitation:

- Changes in the eligibility requirements;
- Amount of credits in a Reimbursement Account; and
- Benefits provided and termination of all or a portion of the coverage provided under the Plan.

No oral statements or representations can amend the Plan. The Company makes no promise to continue the Plan or the benefits offered under the Plan in the future, and individuals have no vested right to the Plan or the benefits offered under the Plan.

Benefit Adjustments

The Plan Administrator, in its discretion, may restrict enrollment and/or adjust an individual's benefits to enable the Plan to comply with requirements imposed by the law or required to comply with nondiscrimination provisions of an applicable law, including without limitation ERISA or the Internal Revenue Code. In addition, all benefits payable under the Plan are subject to set-off for any debts owed by an individual to the Plan or the Company to the extent permitted by law as well as for any reimbursement rights the Plan has against the individual or a third party.

Recovery of Overpayment

If a benefit payment to you or on your behalf exceeds for any reason the benefit amount you are entitled to receive in accordance with the terms of the Plan, the Plan Administrator has the right to require the return of the overpayment on request, and upon request you must immediately refund the overpayment as well as help the Plan Administrator obtain the refund of the overpayment from another person or entity.

This includes any overpayment resulting from retroactive awards received from any source, fraud or any error made in processing your claim. The Plan Administrator also has the right, at its option, to recover the overpayment by reducing or offsetting against any future benefit payments. Such rights do not affect any other right of recovery the Plan Administrator may have with respect to such overpayment. In addition, the Plan Administrator reserves the right to obtain the overpayment by any other method permitted by the law. The Plan Administrator will determine in its sole discretion the method by which the repayment of the overpayment shall be made. Failure to repay an overpayment and cooperate with the Plan Administrator in collecting an overpayment may result in loss of coverage under the Plan.

Assignment Prohibited

Except as permitted by this Summary or the Plan Administrator, no individual shall; have any transmissible interest in any benefit under the Plan or any power to anticipate, assign, sell, transfer, alienate, dispose of, pledge or encumber the same, nor shall the Company recognize an assignment thereof, either in whole or in part, nor shall any benefit be subject to attachment, garnishment, execution following judgment or other legal process.

Except as may be required by law, your benefits under the Plan are not subject to the claims of your creditors.

A participant may not assign and/or transfer to anyone his or her right to file a lawsuit against the Plan, the Plan Sponsor, any Participating Employer, the Plan Administrator, any Plan fiduciary, any party-in-interest with respect to the Plan, or anyone else with respect to the Plan.

Misconduct

The Plan Administrator reserves the right to terminate coverage under the Plan for an individual and that individual's dependents if it determines that an individual:

- Engaged in fraud or made misrepresentations with respect to the Plan;
- Engaged in illegal behavior in connection with the Plan;
- Failed to provide requested information or sign any required documentation;
- Failed to cooperate with the Company or the Plan; or
- Engaged in behavior determined by the Plan Administrator to be detrimental or adverse to the Plan.

In the case of fraud or an intentional misrepresentation of a material fact, the Plan Administrator reserves the right to rescind coverage and deny claim payments retroactively as well as recover any and all benefit payments already made. The Company also reserves the right to take disciplinary action and all other civil and criminal recourse for such actions.

Right to Information

The Plan Administrator and Claim Administrator have the right to require any person claiming eligibility to participate in, or benefits under, the Plan to:

- Furnish any information or documentation it determines necessary,
- Certify or sign an affidavit attesting to certain facts, and
- Undertake a medical examination or an autopsy in the case of death.

These rights are in addition to, not in lieu of, any rights of the Plan Administrator and Claims Administrator set forth in the Summary.

Funding

The Reimbursement Account described in this summary is a notional arrangement. The arrangement is simply a bookkeeping device that allows the Company and you to keep track of HRA Allocations credited to your account and reimbursements made to you under the Plan. You do not have an interest in the HRA Credits. You have no property rights in the Reimbursement Account. The Reimbursement Account is not funded, nor does it bear interest or accrue earnings of any kind. HRA Credits cannot be paid out to an individual or used for any other purpose than described in the Plan. The Company will pay benefits under the Plan directly from its general assets.

Plan Expenses

The Company may pay the expenses of administering the Plan; however, if the Company does not pay for an expense, then the expense shall be paid out of Plan assets.

Governing Law

The Plan shall be construed in accordance with the applicable provisions of ERISA and the Internal Revenue Code and, to the extent not preempted by federal law, in accordance with the laws of the State of Illinois. Any litigation commenced or arising in connection with the Plan shall be commenced and venued exclusively in the United States District Court for the Northern District of Illinois.

Satisfaction of Claims

Any payment to or for the benefit of any individual, legal representative or person chosen in accordance with the provisions of the Plan shall, to the extent of the payment, be in full satisfaction of all claims against the Plan and the Company, either of which may require the payee to execute a receipted release as a condition precedent to the payment.

Privacy of Protected Health Information

The Plan has been amended to permit the Plan to share your and your dependents' protected health information with the Company and third parties (including the Claims Administrator) for certain purposes, such as operation of the Plan and payment of claims pursuant to the HIPAA Privacy Rules. For more information, review the Plan's Notice of Privacy Practices. You have a right to request a copy of this notice.

General Plan Information

Plan Name:	New Castle Stainless Plate, LLC Retiree Health Reimbursement Arrangement (HRA) Account
Type of Plan:	The Plan is a welfare benefit plan providing retiree health care benefits.
Plan Year:	The plan year is the calendar year beginning each January 1 and ending each December 31.
Plan Number:	[NEW192]
Employer/Plan Sponsor:	New Castle Stainless Plate, LLC 549 W State Road 38, New Castle, IN 47362
Participating Employers:	You may obtain a complete listing of participating companies and subsidiaries by contacting the Plan Administrator.
Plan Sponsor's Employer Identification Number:	35-1580158
Plan Administrator:	New Castle Stainless Plate, LLC 549 W State Road 38, New Castle, IN 47362
Claims Administrator:	Mercer, PO Box 424 Escondido, CA 92033 1-855-429-8812
Agent for Services of Legal Process:	Chief Officer, New Castle Stainless Plate, LLC P.O. Box 370 New Castle, IN 47362 (765) 529-0120