BARNES GROUP INC.

HEALTH AND WELFARE PLAN

(Plan No. 518)

Amended and Restated Effective January 1, 2021

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BARNES GROUP INC.

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ARTICLE I: PLAN AND PURPOSE

1.1 Establishment. Barnes Group Inc. (the "***Company***") established the Barnes Group Inc. Health and Welfare Plan (the "***Plan***") effective January 1, 2006. The Plan is hereby amended and restated, effective as of January 1, 2021.

1.2 Purpose. The purpose of the Plan is to provide to Participants certain welfare and fringe benefits pursuant to specified insurance policies and contracts or funding arrangements established by the Employer. Notwithstanding the number and types of benefits incorporated hereunder, the Plan is, and shall be treated as, a single welfare and fringe benefit plan to the extent permitted under ERISA.

The Plan is intended to meet all applicable requirements of the Internal Revenue Code (the "***Code***") and the Employee Retirement Income Security Act ("***ERISA***"), as well as rulings and regulations promulgated thereunder. For certain Benefit Programs, this information, including Schedules 1 and 2 of the Plan, together with information contained in the Certificates of Coverages, participant booklets and benefit summaries of the component Benefit Programs constitutes the Summary Plan Description required by ERISA. To the extent required, the Plan is also intended to be maintained as required by, and in accordance with, M.G.L. c. 151F, 956 CMR 4.00 and such other rules and regulations of the Massachusetts Commonwealth Health Insurance Connector Authority, as amended from time to time.

1.3 Benefit Programs. Benefits are provided to Participants through one or more Benefit Programs sponsored or maintained by the Employer or one or more Participating Employers. Benefit Programs may be funded or unfunded, insured or uninsured, or a combination thereof, and may provide varying benefits to different groups of Covered Employees of the Employer or a Participating Employer and their respective Dependents. The separate Benefit Programs that are incorporated into the Plan are identified on Appendix B and Appendix C. Separate Program Documents which describe the specific benefits provided by each Benefit Program, the individuals eligible for coverage under each Benefit Program, and the other terms and conditions of each Benefit Program, as amended from time to time, are incorporated herein by reference. The Plan supersedes and replaces any document defining the terms of or describing a Benefit Program which is not incorporated and made part of the Plan. If the Benefit Program is insured and there is a conflict between the specific terms of a Program Document and the terms of the Plan, the Program Document will control. For all other Benefit Programs, if there is a conflict between the specific terms of a Program Document and the terms of the Plan or summary plan description, the Plan and summary plan description will control (unless contrary to applicable law), except that any terms exclusively applicable to a Benefit Program will be set forth in the applicable Program Document.

ARTICLE II: DEFINITIONS

Whenever used herein, the following terms have the meanings set forth below unless a different meaning is clearly required by the context or pursuant to the terms of the applicable Benefit Program.

2.1 "Affordable Care Act" or "ACA" means the Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010)), amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (124 Stat. 1029 (2010)), as further amended from time to time.

2.2 "Administrator" means the Senior Vice President, Human Resources of Barnes Group Inc. or such other person or persons designated to administer the Plan pursuant to Article V.

2.3 "Benefit Program" means a written arrangement incorporated into this Plan that is offered by the Employer which provides an employee benefit, including those that would be treated as an "employee welfare benefit plan" under Section 3(1) of ERISA if offered separately. Benefit Program also means any plan established pursuant to Section 125 or Section 132(f) of the Code. Each Benefit Program is identified in Appendix B and Appendix C and is incorporated into and a part of the Plan. The documents for each Benefit Program are incorporated into this document. The Employer or Administrator, as applicable, may add or delete a Benefit Program from the Plan by amending Appendix B and Appendix C without any need to otherwise amend the Plan. An amendment to Appendix B and Appendix C may be made by any authorized officer or representative of the Employer and shall not require approval by the Employer's Board of Directors.

2.4 "Breach" means the acquisition, access, use, or disclosure of an individual's PHI in a manner not permitted under the Privacy Rule which compromises the security or privacy of the PHI. The term "Breach" does not include:

(a) an unintentional acquisition, access or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access, or use was in good faith and within the scope of authority and does not result in a further impermissible use or disclosure;

(b) an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or

(c) a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

2.5 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985 as from time to time amended.

2.6 "Code" means the Internal Revenue Code of 1986, as amended, and its regulations.

2.7 "Covered Employee" means an employee of the Employer who satisfies the minimum eligibility requirements of the applicable Benefit Program (such as requisite hours, location and business unit) as set forth in the Program Documents. Specifically, for purposes of group medical coverage, the provisions of the summary plan description will control. To the extent not described in the Program Documents:

(a) Dental Coverage: For purposes of the dental care coverage component Benefit Program, a Covered Employee shall also include an individual who has terminated employment but is entitled to benefits under a severance arrangement with the Employer for a specified period ("Severance Period"). Unless the applicable severance arrangement provides otherwise, such individual shall cease to be a Covered Employee upon the expiration of the Severance Period.

(b) Benefits during Phased Retirement: A Covered Employee also includes an eligible employee regularly scheduled to work at least 30 hours per week who is a Covered Employee under a Benefit Program under the Plan and who:

(i) has reached age sixty-two (62);

(ii) has completed at least ten (10) years of service;

(iii) has elected, with agreement of the Company, to reduce his or her regularly scheduled hours to less than thirty (30) hours per week, but is still scheduled to work at least twenty (20) hours per week;

(iv) begins in-service pension benefit payments under the provisions of Part A of the Barnes Group Inc. Consolidated Pension Plan while still working for the Company; and

(v) was in an eligible class of employees entitled to participate in a component Benefit Program under the Plan immediately before his or her election to begin in-service pension payments under the provisions of Part A of the Barnes Group Inc. Consolidated Pension Plan.

Such individual shall cease to be a Covered Employee on the date the in-service pension payments under the terms of the Barnes Group Inc. Consolidated Pension Plan are suspended. Component Benefit Programs based upon salary (e.g., life and AD&D insurance, disability insurance) will be prorated based on reduction in hours/salary during such in-service pension payment period.

2.8 "Dependent" means, for all purposes of the Plan:

(a) A Covered Employee's unmarried children (including stepchildren, legally adopted children and foster children) or sibling, stepsibling or any descendants of these relatives such as grandchildren, nieces or nephews who, at the time in question:

(i) are considered "dependents" of the Covered Employee within the meaning of Section 152 of the Code; and

(ii) satisfy the eligibility requirements set forth in the Benefit Program elected by the Covered Employee.

Notwithstanding anything in this Section 2.8(a) to the contrary, for purposes of component Benefit Programs which are Group Health Plans, Dependent shall include a Covered Employee's children up to age twenty-six (26).

(b) A Covered Employee's Spouse.

(c) A Covered Employee's qualifying relative, who at the time in question: (i) is considered a "dependent" of the Covered Employee within the meaning of Section 152 of the Code; and (ii) satisfies the eligibility requirements set forth in the Benefit Program elected by the Covered Employee.

(d) If permitted under the terms of the Benefit Program elected by the Participant, a Participant's Domestic Partner, provided the Domestic Partner satisfies the eligibility requirements set forth in the applicable Benefit Program.

(e) If permitted under the terms of the Benefit Program elected by the Participant, the Eligible Dependents of a Participant's Domestic Partner, provided the eligibility requirements set forth in the applicable Benefit Program are met.

(f) An individual who is determined to be an alternate recipient of a Covered Employee under a QMCSO.

2.9 "Domestic Partner" means an individual of the same or opposite gender as the Participant and who satisfies all of the following requirements:

(a) is in a committed relationship with, and is the sole partner of, a U.S. based salaried or non-union hourly unmarried Participant and the relationship is intended to be permanent;

(b) is at least eighteen (18) years of age and mentally able to contract;

(c) is unmarried (including common-law marriage), and not in a domestic partnership with anyone else.

(d) is not related to the Participant by blood to a degree of closeness which would prohibit legal marriage in the state in which the individual and the Participant legally resides;

(e) is jointly responsible with the Participant for common welfare, household and living expenses;

(f) has resided with the Participant for at least twelve (12) continuous months, currently resides with the Participant and intends to continue residing with the Participant indefinitely;

(g) completes with the Participant and submits an Affidavit of Domestic Partnership to Employer, on a form approved in the sole discretion of the Employer, along with satisfactory proof of the matters set forth in items (a) – (f) above; and

(h) agrees with the Participant in writing to give Employer a signed Notice of Dissolution of Domestic Partnership within thirty-one (31) days after the domestic partnership ends.

2.10 "Effective Date" The Plan was originally effective January 1, 2006. This amendment and restatement are effective January 1, 2021.

2.11 "Election" means the choice by a Participant to enroll in one or more of the Benefit Programs under the enrollment rules of the Plan.

2.12 "Eligible Benefit Expense" means the Participant's share of the cost of coverage under the Benefit Programs funded by the Employer or a Participating Employer, if any, and the Participant's share of the cost of premiums paid to the Group Benefit Providers by the Employer and Participating Employer, if applicable, for the Benefit Programs.

2.13 "Eligible Dependents of a Domestic Partner" means the children of a Participant's Domestic Partner who is enrolled in the applicable Benefit Program and who meet the requirements set forth in the applicable plan or policy for eligible dependents.

2.14 "Employer" means the Company or any successor that agrees to continue the Plan. The term Employer as the term is used throughout this document, shall include Participating Employers as the context so requires, or as required by any provision of law.

2.15 "ERISA" means the Employee Retirement Income Security Act of 1974 as from time to time amended.

2.16 "FMLA" means the Family and Medical Leave Act of 1993, as amended from time to time.

2.17 "Genetic Information" means "genetic information" as such term is defined in 45 C.F.R. §160.103. Notwithstanding the foregoing, Genetic Information shall be treated as "health information."

2.18 "Group Benefit Providers" means the insurance companies which issue the group Benefit Programs.

2.19 "Group Health Plan" has the same meaning given that term by section 2791(a) of the Public Health Service Act as amended from time to time.

2.20 "Health Care Operations" has the same meaning given that term by 45 C.F.R. §164.501.

2.21 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 as amended from time to time.

2.22 "Participant" means any individual who participates in the Plan in accordance with Article III, or a Spouse, former Spouse or Dependent who has made a separate election under COBRA or a Domestic Partner or Eligible Dependent of a Domestic Partner who has made a separate election under a COBRA-like continuation program (if and as applicable) or who is entitled to coverage under a QMSCO.

2.23 "Participating Employer" means each Participating Employer is identified in Appendix A. The Company shall amend Appendix A as needed to reflect a Participating Employer's adoption of the Plan or withdrawal from the Plan, without any need to otherwise amend the Plan. Amendment of Appendix A may be made by any authorized officer or representative of the Company and shall not require approval of the Company's Board of Directors.

2.24 "Payment" means "payment" as such term is defined in 45 C.F.R. §164.501.

2.25 "Period of Coverage" means the Plan Year except for a new or requalifying Participant who satisfies the participation requirements of Article III after the Effective Date, in which case the Period of Coverage shall be the time period commencing on the first day of the payroll period following receipt by the Administrator of an Election by the Participant and ending on the last day of the Plan Year.

2.26 "PHI" means protected health information as defined by 45 C.F.R. §160.103, as amended from time to time.

2.27 "Plan" means the Barnes Group Inc. Health and Welfare Plan, as set forth herein, and as amended from time to time.

2.28 "Plan Year" means the 12-month period ending on each December 31.

2.29 "Program Documents" means the written summary of the terms of each separate Benefit Program which may consist of a summary plan description, separate plan document, summary of benefits coverage, insurance company contract or other document, each of which are incorporated herein by reference.

2.30 "QMSCO" means a Qualified Medical Child Support Order as defined in Section 609(a) of ERISA.

2.31 "Spouse" means an individual who is legally married to a Participant. A legally married spouse includes an individual married to a person of the same sex and the term "marriage" includes such marriages of individuals of the same sex.

2.32 "Underwriting Purposes" means "underwriting purposes" as such term is defined in 45 C.F.R. §164.501.

2.33 "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

ARTICLE III: PARTICIPATION AND BENEFITS

3.1 Commencement of Participation. A Covered Employee will become eligible for participation in the Plan only if and to the extent the Covered Employee is eligible with respect to the particular benefit in question pursuant to the terms of the Benefit Program(s) specified in Appendix B and Appendix C. Each Benefit Program may also designate those beneficiaries, if any, of a Covered Employee that are eligible to receive benefits from the Benefit Program and set forth the criteria for their eligibility under the Benefit Program. The Employer or Participating Employer may require that a Covered Employee complete a designated election form prior to commencement of participation in the Plan. If a Covered Employee fails to submit the designated election form to the Administrator within a timely manner following the date the Covered Employee is first eligible to participate in the Plan, the Covered Employee may commence participation as of the first day of the next following Period of Coverage.

3.2 Termination of Participation. A Participant will cease to be a Participant in the Plan on the earlier of (a) the date on which the Plan terminates, (b) the date the Participant is no longer a Covered Employee under the applicable Benefit Program, or (c) the date the Participant is no longer a Dependent under the applicable Benefit Program. Termination of participation in the Plan shall not prevent a former Participant from continued coverage or benefits under the Benefit Programs to the extent provided by such program or in accordance with Section 3.3, if applicable.

Component Benefit Programs which are Group Health Plans shall not rescind coverage with respect to an enrollee once the enrollee is a Participant in accordance with Section 1001(5) of ACA and the regulations which may be issued from time to time thereunder, except that this paragraph shall not apply to a Participant who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the Plan.

3.3 Continuation of Coverage. Article IX includes a description of the rights and obligations of Participants with respect to continuation coverage and information about "qualifying events", notice and election requirements and procedures and duration of coverage.

3.4 Prohibition of Pre-existing Condition Exclusions. Group Health Plan component Benefit Programs may not impose any pre-existing condition exclusion with respect to such coverage for enrollees who are under nineteen (19) years of age, in accordance with Section 1201 of ACA and the regulations which may be issued from time to time thereunder. Group Health Plan component Benefit Programs may not impose any preexisting condition exclusion with respect to such coverage for any enrollees.

3.5 Coverage of Preventive Health Services. A Group Health Plan component Benefit Program shall provide coverage and shall not impose any cost-sharing requirements, in accordance with Section 2713 of the Public Health Services Act and the regulations which may be issued from time to time thereunder for:

(a) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

(b) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(c) with respect to infants, children, and adolescents, evidence informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(d) with respect to women, to the extent not described in subsection (a) evidence-informed preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration.

3.6 Patient Protections. With respect to each Group Health Plan component Benefit Program:

(a) if such Group Health Plan component Benefit Program requires or provides for designation by a Participant, beneficiary, or enrollee of a participating primary care provider, then the component Benefit Program shall permit each Participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual, in accordance with Section 1001(5) of ACA and the regulations which may be issued from time to time thereunder;

(b) if such Group Health Plan component Benefit Program provides or covers any benefits with respect to services in an emergency department of a hospital, then the component Benefit Program shall cover emergency services in accordance with Section 1001(5) of ACA and the regulations which may be issued from time to time thereunder;

(c) in the case of a person who has a child who is a Participant, beneficiary, or enrollee, if such Group Health Plan component Benefit Program requires or provides for the

designation of a participating primary care provider for the child, the component Benefit Program shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the component Benefit Program in accordance with Section 1001(5) of ACA and the regulations which may be issued from time to time thereunder; and

(d) no Group Health Plan component Benefit Program may require authorization or referral by the Plan, issuer, or any person (including a primary care provider) in the case of a female Participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology in accordance with Section 1001(5) of ACA and the regulations which may be issued from time to time thereunder.

ARTICLE IV: ELECTIONS AND FUNDING

4.1 Election Procedure. A Participant may elect to enroll in benefits under the Plan by filing a written Election with the Administrator, if required by the Administrator. If required, the designated Election form, in a form approved by the Administrator, must be timely received by the Administrator on a date determined by the Administrator. Such date will be determined in the sole discretion of the Administrator. Elections automatically terminate on the date on which the Participant ceases to be a Covered Employee.

4.2 Payment of Premiums. Premiums for the applicable Benefit Programs will be paid solely from the general assets of the Employer and Participating Employers. Premium payments will include contributions by Participants as well as Employer and Participating Employer contributions. Nothing contained in the Plan shall require the Employer and Participating Employers to maintain a fund for the benefit of any Participant or Dependent, and no Participant or Dependent shall have any claim against, right to, or interest in any fund, account or asset of the Employer and Participating Employers from which premiums are paid. If the Employer or Participating Employers for any reason fail to pay premiums for or otherwise implement the relevant Benefit Programs for Participants, the sole liability of the Employer or Participating Employers shall be limited to the amount of premiums otherwise payable. The Employer shall not be responsible for any losses to Participants or Dependents for such failure beyond the amount of such premiums.

4.3 Benefits.

(a) Except as provided in subsection (b), the Employer and Participating Employers shall have no responsibility for the payment of benefits, such benefits being payable solely by the Group Benefit Providers in accordance with the terms of the underlying Benefit Programs. Subject to subsection (b), the sole responsibility of the Employer and Participating Employers shall be for the payment of its share of the premiums under the Benefit Programs and the Group Benefit Providers will have the sole responsibility to pay all valid benefit claims pursuant to the terms of the underlying Benefit Programs. All claims for such benefits shall be filed with the

applicable Group Benefit Provider which has the sole right to determine what benefits are payable under the terms of the Benefit Programs.

(b) Notwithstanding the provisions in subsection (a) to the contrary, and subject to the terms of any agreement made between the Employer and any third party administrator, the Employer and the Participating Employers will have the sole responsibility to pay benefit claims pursuant to the terms of the Benefit Program(s) listed on Appendix C.

4.4 Participant's Responsibilities. Each Participant shall be responsible for providing the Employer or the Participating Employer with the Participant's current contact information (address, phone number, etc.) and, if applicable, any notices required under Article IX. Any notices required or permitted to be given by a Participant hereunder shall be deemed given if directed to the Participant's current address on file with the Employer and mailed by regular United States mail or if delivered pursuant to Department of Labor regulations. Neither the Employer nor Participating Employers shall have any obligation or duty to locate a Participant.

4.5 No Lifetime Limits. Group Health Plan component Benefit Programs shall not impose lifetime limits on the dollar value of health benefits for any Participant or beneficiary in accordance with Section 1001(5) of ACA and the regulations which may be issued from time to time thereunder.

4.6 No Annual Limits. Group Health Plan component Benefit Programs shall not impose annual limits on the dollar value of health benefits for any Participant or beneficiary in accordance with Section 1001(5) of ACA and the regulations which may be issued from time to time thereunder.

ARTICLE V: ADMINISTRATION

5.1 Administrator. The Senior Vice President, Human Resources of the Company is designated as the Administrator. The Senior Vice President, Human Resources of the Company may delegate in writing his or her duties under the Plan to one or more officers or employees, or to individuals or entities independent of the Employer.

5.2 Powers of the Administrator. The Administrator shall have all powers which are necessary to administer the Plan, including but not limited to the following:

(a) to interpret the provisions of the Plan and decide questions of eligibility to participate. In the event that the provisions of any Benefit Program conflict with or contradict the provisions of this document or any other Benefit Program, the Administrator shall use its discretion to interpret the terms and purpose of the Plan so as to resolve any conflict or contradiction. However, the terms of this document may not enlarge the rights of a Participant, Dependent or beneficiary to benefits available under any Benefit Program.

(b) to establish rules and prescribe any forms necessary or desirable for the administration of the Plan.

5.3 Actions of the Administrator. All determinations, interpretations, rules and decisions of the Administrator shall be in the sole discretion of the Administrator and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan. All decisions and actions by the Administrator shall be applied uniformly and consistently to all Participants so that all persons similarly situated will receive substantially the same treatment.

(a) The Administrator shall have all other powers necessary or desirable to administer the Plan, including, but not limited to, the following:

(i) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;

(ii) To prescribe procedures to be followed for the implementation of requirements under Affordable Care Act, including reporting requirements under Section 6056 of the Code, which procedures are incorporated herein by reference.

(iii) To prepare and distribute information explaining the Plan to Participants;

(iv) To receive from Participating Employers, Participants, and beneficiaries such information as shall be necessary for the proper administration of the Plan;

(v) To keep records of elections, claims, disbursements for claims under the Plan, and any other information required by ERISA or the Code;

(vi) To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents it deems advisable;

(vii) To purchase any insurance deemed necessary for providing benefits under the Plan;

(viii) To accept, modify or reject Participant elections under the Plan;

(ix) To promulgate election forms and claim forms to be used by Participants;

(x) To prepare and file any reports or returns with respect to the Plan required by the Code, ERISA or any other laws;

(xi) To determine and announce any Participant contributions required hereunder;

(xii) To determine and enforce any limits on benefits elected hereunder;

(xiii) To take such action as may be necessary to cause the payroll deduction of any Participant contributions required hereunder; and

(b) To correct errors and to make equitable adjustments for mistakes made in the administration of the Plan; specifically, and without limitation, to recover erroneous overpayments made from the Plan to a Participant or beneficiary, in whatever manner the Administrator determines is appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant or beneficiary.

5.4 Delegation of Duties. The Administrator, in its sole discretion, may delegate responsibilities for the operation and administration of the Plan, may designate fiduciaries other than those named in the Plan, and may allocate or reallocate fiduciary responsibilities under the Plan.

5.5 Indemnification. The Administrator and any delegate who is an Employee of the Employer or of a Participating Employer shall be fully indemnified by the Employer or the Participating Employer against all liabilities, costs, and expenses (including defense costs, but excluding any amount representing a settlement unless such settlement is approved by the Employer or Participating Employer) imposed upon it in connection with any action, suit, or proceeding to which it may be a party by reason of being the Administrator or having been assigned or delegated any of the powers or duties of the Administrator, and arising out of any act, or failure to act, that constitutes or is alleged to constitute a breach of such person's responsibilities in connection with the Plan, unless such act or failure to act is determined to be due to gross negligence or willful misconduct.

5.6 Fiduciary Duties and Responsibilities. Each Plan fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of the Participants and each Dependent or beneficiary for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of administering the Plan and in accordance with the terms of the Plan. Each fiduciary, in carrying out such duties, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in exercising such authority. A fiduciary may serve in more than one fiduciary capacity. Unless liability is otherwise provided under Section 405 of ERISA, a named fiduciary shall not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a named fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

5.7 Named Fiduciary. The Administrator is the "Named Fiduciary" for purposes of ERISA. Notwithstanding the foregoing, the Administrator may delegate fiduciary duties in accordance with Section 5.4.

5.8 Participant's Responsibilities. Each Participant shall be responsible for providing the Administrator and/or the Employer with the Participant's and each Dependent's or beneficiary's current address. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Administrator nor the Employer shall have any obligation or duty to locate a Participant,

Dependent or beneficiary. If a Participant, Dependent or beneficiary becomes entitled to a payment under the Plan and such payment is delayed or cannot be made:

(a) because the current address according to the Employer's records is incorrect;

(b) because the Participant, Dependent or beneficiary fails to respond to a notice sent to the current address according to the Employer's records;

(c) because of conflicting claims to such payments; or

(d) because of any other reason;

(e) the amount of such payment, if and when made, shall be that determined under the provisions of the Plan without payment of any interest or earnings.

5.9 Unclaimed Benefits. If, within two (2) years after any amount becomes payable hereunder to a Participant, Dependent or beneficiary and the same shall not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care shall have been exercised by the Administrator in attempting to make such payments, the amount thereof shall be forfeited and shall cease to be a liability of the Plan.

5.10 Subrogation, Reimbursement and Recovery for Third Party Liability. As a condition for receiving benefits under the Plan, each Participant agrees to and grants the Plan the right to subrogation, the right to reimbursement, and the right of recovery as set forth herein. When a Participant becomes sick or injured as a result of the act or omission of another person or party and the Participant receives benefits under the Plan for such sickness or injuries, the Participant must reimburse the Plan for benefits received from all recoveries from a third party (whether by lawsuit, settlement or otherwise) and the Plan's share of the recovery will not be reduced because the Participant has not received the full damages claimed, unless the Plan agrees in writing to such a reduction. If the Participant breaches this third-party reimbursement provision, then the Participant agrees to indemnify the Plan for all costs of recovering third party reimbursements. To the extent that any Benefit Program also contains provisions regarding subrogation, reimbursement, or right to recovery of expenses, this Section 5.10 and the applicable Benefit Program shall both apply so as to grant the Plan the greatest possible rights with respect to subrogation, reimbursement, and recovery of such expenses or benefits. Except as specifically provided otherwise in an applicable Benefit Program, this Section 5.10 shall apply to any health or disability benefit provided through the Benefit Programs.

(a) Right of Subrogation. As a condition to participation in or the receipt of benefits under the Plan, each Participant agrees that the Plan shall have the right of subrogation with respect to the full amount of benefits paid to or on behalf of a Participant as the result of an injury, illness, disability or death that is or may be the responsibility of any third party. The Plan shall also have a lien upon any recovery from such third party to the full amount of benefits paid and may, at its option, file suit or intervene in any pending lawsuit to secure and protect its rights. The Plan's right of subrogation shall apply to the first dollar of any recovery obtained from the

third party, even if the recovery obtained is less than the amount needed to make the Participant whole.

(b) Reimbursement Agreement. If a Participant incurs expenses that are excluded in accordance with this provision of the Plan because they are or may be the responsibility of a third party, the Participant may be required, as a prerequisite to receiving Plan benefits, to sign a reimbursement agreement in a form acceptable to the Administrator acknowledging the Participant's obligation to reimburse the Plan for any benefits or expenses paid by the Plan from the first dollars recovered from any source. If expenses are incurred by a minor, the Administrator may require that the minor's parent or legal guardian execute the reimbursement agreement and agree to be bound by it. The Administrator may, in its discretion, withhold benefit payments that might otherwise be advanced, and/or initiate an action at law or in equity in its own name or in the name of the Participant, in order to enforce, secure, or protect the Plan's rights under this provision. If the Participant elects not to execute such an agreement, the Plan is not obligated to provide any benefit payments.

(c) Right of Reimbursement. Whether or not a Participant executes a reimbursement agreement, in the event that the Plan provides benefits to a Participant and the Participant recovers a payment, either by settlement, judgment, no-fault automobile insurance statute, or otherwise, from any third party or other source, then the Participant shall immediately reimburse the Plan for the full amount of any and all benefits paid in connection with such injury, illness, disability or death, up to the amount of the recovery. This right of reimbursement applies regardless of the label assigned to the recovery, and regardless of any purported allocation or itemization of such recovery to specific types of injuries. If the recovery is for damages other than for medical or dental care expenses, such as pain and suffering, the Participant will still be required to reimburse the Plan first. The Plan shall have a lien upon any such recovery in the amount of benefits or expenses paid by the Plan. The Plan's right of reimbursement shall apply to the first dollar of any recovery obtained from the third party, even if the recovery obtained is less than the amount needed to make the Participant whole.

(d) Procedures for Subrogation and Reimbursement. Each Participant or his or her legal representative must do whatever is requested by the Administrator with respect to the exercise of the subrogation and reimbursement rights of the Benefit Program and the Employer and Participating Employers and will do nothing to prejudice those rights. In addition, each Participant or his or her legal representative, in conjunction with making a claim for Benefit Program benefits, must inform the Administrator in writing whether the Participant was injured by a third party, and must provide the following information in a timely, prompt fashion as a condition to receipt of Benefit Program benefits:

(i) the name, address, and telephone number of the third party that in any way caused the injury, and of the attorney representing the third party;

(ii) the name, address, and telephone number of the third party's insurer and any insurer of the Participant;

(iii) the name, address, and telephone number of the Participant's attorney with respect to the third party's act;

(iv) prior to the meeting, the date, time and location of any meeting between the third party or his or her attorney and the Participant, or his or her attorney;

(v) all terms of any settlement offer made by the third party or his or her insurer or the Participant's insurer;

(vi) all information discovered by the Participant, or his or her attorney, concerning the insurance coverage of the third party;

(vii) the amount and location of any funds that are recovered by the Participant from the third party or his or her insurer or the Participant's insurer, and the date that the funds were received;

(viii) prior to settlement, all information related to any oral or written settlement agreement between the Participant and the third party or his or her insurer or the Participant's insurer;

(ix) all information regarding any legal action that has been brought on behalf of a Participant against the third party or his or her insurer; and

(x) all other information requested by the Administrator.

No Participant (or the person's legal representative) may retain an attorney with respect to the third party without the prior written consent of the Administrator. As a condition of receiving benefits under the Benefit Program, each Participant (and that person's legal representatives) hereby:

(xi) waives the assertion of any attorney-client privilege against an Employer with regard to an attorney retained by the Participant;

(xii) agrees that an Employer may assume, at its discretion, the defense of any action that has been or could be brought against the third party by the Participant (or that person's legal representatives);

(xiii) agrees that an Employer must be given the opportunity to approve any settlements before they are made with the third party;

(xiv) agrees to consent to judgment for the Plan;

(xv) agrees not to assert a defense under Section 502 of ERISA to a claim made by the Plan; and

(xvi) agrees that a claim brought by the Plan to enforce its rights under this Section 5.10 is an equitable claim.

Any funds recovered by a Participant (or that person's legal representative) from a third party (or the third party's insurer) must and are deemed to be held in constructive trust for the benefit of the Benefit Program and the Employer to the extent of the amount of Benefit Program benefits until reimbursement, with the Participant (or that person's legal representative) as trustee and fiduciary.

(e) Coverage for Expenses Caused by a Third Party. The Administrator may, in its sole discretion, cease to pay benefits under a Benefit Program if a Participant refuses to execute a reimbursement agreement required by the Administrator. The Administrator may cease to pay benefits subject to a reimbursement agreement if, in the discretion of the Administrator, the Participant has failed or is failing to fulfill his or her duty to cooperate or to comply with the provisions of this Section 5.10.

(f) Right of Recovery and Offset. The Plan shall have the right to recover any benefits paid to a Participant or his or her health care provider that a Participant fails to reimburse to the Plan under the provisions of this Section 5.10. To the extent not otherwise paid to the Plan, the amount due to the Plan will reduce any other present or future benefits payable from the Plan to or on behalf of the Participant. In addition, the Administrator may, in its sole discretion, employ any other lawful means to recover overpayment on behalf of the Plan. These rights are in addition to any other rights and remedies that the Plan may have.

(g) Attorneys' Fees and Expenses. Neither the Benefit Program nor any Employer or Participating Employer will be responsible for any attorneys' fees or expenses incurred in connection with any sums recovered by the Participant (or that person's legal representative) from the third party; provided, however, that if the Administrator has consented to the retention of the Participant's attorney, the total amount for which the Participant is liable shall not exceed his or her recovery net of all legal fees and expenses.

ARTICLE VI: PARTICIPATING EMPLOYERS

6.1 Adoption of Plan. With the consent of the Employer, the Plan may be adopted by a Participating Employer, by action of its governing body or an authorized officer.

6.2 Administration. As a condition to adopting the Plan, and except as otherwise provided herein, each Participating Employer shall be deemed to have authorized the Administrator to act for it in all matters arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Administrator.

6.3 Termination of Participation. Each Participating Employer may cease to participate in the Plan or in any Benefit Program with respect to its Employees, by written resolution by its governing body or an authorized officer and approval by the Administrator. Notwithstanding the foregoing, merger and/or purchase or sale agreements or other transaction

documents which provide for a cessation of participation by a Participating Employer in the Plan or in any Benefit Program with respect to its Employees shall be deemed to be sufficient authorized termination action.

ARTICLE VII: MISCELLANEOUS

7.1 Amendment of the Plan. The Company reserves the discretionary right to modify or amend the Plan in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by its governing body or its designee and duly executed on behalf of the Company. However, no Plan amendment shall be valid which would cause the Plan to fail any applicable qualification requirements of Sections 79, 105, 125 or 129 of the Code, or any successors thereto, so long as such statutes apply to the Plan. The Administrator shall have the right and the discretion to amend any provision of the Plan that is administrative, procedural, or ministerial in nature, and any written policy, rule, procedure or similar action adopted by the Administrator that is inconsistent with any administrative, procedure or ministerial provision of the Plan shall be deemed an amendment. Notwithstanding the foregoing, the Administrator, or its designee, may amend one or more Benefit Programs to the extent that such amendment (a) is necessary or appropriate for such Benefit Programs to remain in compliance with applicable laws or regulations; (b) will not increase the anticipated annual cost of the Benefit Program by more than 15% or significantly decrease the benefits to any Participant or covered Dependent; or (c) is intended only to implement directions and transactions approved by the governing body of the Employer.

7.2 Termination of the Plan. The Company reserves the discretionary right to terminate the Plan or any Benefit Program at any time as designated by a written instrument adopted by its governing body or its designee and duly executed on behalf of the Company.

7.3 Plan Not a Contract of Employment. The Plan is not an employment agreement and does not assure the continued employment of any employee or Participant for any period of time. Nothing contained in the Plan shall interfere with the right of the Employer and Participating Employer(s) to discharge an employee or Participant at any time, regardless of the effect such discharge will have upon that individual as a Participant in the Plan. All Participants, unless otherwise provided in an employment agreement, are at-will employees of the Employer or a Participating Employer and the Plan does not change that status.

7.4 Applicable Law. The Plan shall be construed and enforced according to the laws of the State of Connecticut, notwithstanding its choice of law provisions, to the extent not preempted by any applicable federal law.

7.5 Non-Alienation of Benefits. No benefit, right or interest of any Participant, Dependent or Beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, garnishment, execution, pledge, encumbrance or charger, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law. Neither the Plan

sponsor, the Company, the Employer, any Participating Employer nor the Plan Administrator will accept or recognize any assignment of rights, benefits or interest under the Plan to a health provider or facility for any reason, including but not limited to any claim for damages resulting from a violation or alleged violation of the terms of the Plan, including any breach of fiduciary duties under ERISA. Further, the payment of any claims for services rendered to a health provider will not result in a grant of any rights under the Plan or ERISA to such health provider.

7.6 Venue. The exclusive venue for all disputes raised under the Plan shall be the applicable state and/or federal courts having jurisdiction over and located within Hartford, Connecticut. By filing an Election to enroll in one or more Benefit Programs, Participants agree and consent to the jurisdiction of the state and federal courts located within Hartford, Connecticut.

7.7 Severability And Construction. The captions contained herein are inserted only as a matter of convenience and reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and neuter are interchangeable.

7.8 Expenses. Any expenses incurred in the administration of the Plan shall be paid by the Plan, by the Employer and/or by one or more Participating Employers, as determined in the discretion of the Employer.

7.9 Regulatory References. Any references herein to a section of the Code of Federal Regulations ("***C.F.R.***") shall mean the cited section as in effect or as such may be amended from time to time, and for which compliance by the Plan is required.

ARTICLE VIII: HIPAA PRIVACY AND SECURITY

8.1 General. This Article applies to benefits offered through the Plan that are also deemed to be group health plans under 45 C.F.R. §160.103, ("***HIPAA Health Plan***") and does not apply to non-health benefits or benefits that provide for the cost of excepted benefits that are listed in 42 U.S.C. §300gg-91(c)(1). The HIPPA Health Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA, including but not limited to health care treatment, health care operations and as required by law.

8.2 Privacy Practices and Policy. The HIPAA Privacy Rule (the "***Privacy Rule***"), as amended, requires the implementation of certain policies and procedures addressing permitted uses and disclosures of a Participant's PHI in a HIPAA Health Plan, and ensuring the privacy rights of Participants in the HIPAA Health Plan. The Plan adopted a HIPAA Privacy Policy, as amended and restated effective October 1, 2017, as amended from time to time (the "***Policy***") which sets forth these policies and procedures as required under HIPAA for its HIPAA Health Plans. The Policy is incorporated herein by reference. If any provision of the Policy is inconsistent with HIPAA or a more restrictive applicable state privacy law (to the extent not preempted), the Policy

will be interpreted to comply with such law. The Policy also describes the rights that a Participant maintains and the obligations of the HIPAA Health Plans and the Employer with regard to the Participant's PHI under HIPAA. These Policies are also set forth in the Notice of Privacy Practices for the HIPAA Health Plans (the "***Notice***") which was developed and is used in accordance with the Privacy Rule. The Notice is distributed to all new Participants at the time of enrollment in the Plan and available on the Employer's intranet web sites. The Notice was first effective as of April 14, 2003.

8.3 Authorized Employees. Only Authorized Employees, as defined in this section, shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of a HIPAA Health Plan. The use or disclosure of PHI by Authorized Employees shall be restricted to the HIPAA Health Plan administration functions that the Employer performs on behalf of a HIPAA Health Plan.

(a) Employees of the Employer who perform the following functions on behalf of the HIPAA Health Plans are Authorized Employees:

(i) claims determination and processing functions;

(ii) HIPAA Health Plan vendor relations functions;

(iii) benefits education and information functions;

(iv) HIPAA Health Plan administration activities;

(v) legal department activities;

(vi) HIPAA Health Plan compliance activities;

(vii) information systems and HRIS support activities;

(viii) payroll and finance activities;

(ix) internal audit functions; and

(x) human resources functions.

(b) In addition to those individuals described in subsection (a) above, the Administrator who performs claims appeals and other decision-making functions on behalf of the HIPAA Health Plans, the HIPAA Health Plans' Privacy and Security Official, and Employer employees to whom the HIPAA Health Plans' Privacy and Security Official has delegated any of the following responsibilities shall also be Authorized Employees:

(i) implementation, interpretation, and amendment of the Privacy Policy;

(ii) Privacy Rule training for Employer employees;

(iii) investigation of and response to complaints by Participants and/or employees;

(iv) preparation and maintenance of a HIPAA Health Plan privacy notice;

(v) distribution of the Notice;

(vi) response to requests by Participants to inspect or copy PHI;

(vii) response to requests by Participants to restrict the use or disclosure of their PHI;

(viii) response to requests by Participants to receive communications of their PHI by alternate means or in an alternate manner;

(ix) amendment and response to requests to amend Participants' PHI;

(x) response to requests by Participants for an accounting of disclosures of their PHI;

(xi) response to requests for information by the Department of Health and Human Services;

(xii) approval of disclosures to law enforcement or to the military for government purposes;

(xiii) maintenance of records and other documentation required by the Privacy Rule or the Security Rule;

(xiv) negotiation of Privacy Rule and Security Rule provisions into contracts with third party service providers; or

(xv) approval of access to Electronic PHI.

8.4 Permitted Uses and Disclosures. Authorized Employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain permitted and required functions on behalf of the HIPAA Health Plans in a manner that is consistent with the Privacy Policy.

8.5 Certification Requirement. The HIPAA Health Plans shall disclose PHI and Electronic PHI to Authorized Employees only upon receipt of a certification by the Employer that the Employer agrees:

(a) not to use or further disclose PHI other than as permitted or required by this Article and the Privacy Policy or as required by law;

(b) to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the HIPAA Health Plan;

(c) to take reasonable steps to ensure that any agents, including subcontractors, to whom the Employer provides PHI or Electronic PHI received from the HIPAA Health Plan agree to:

(i) the same restrictions and conditions that apply to the Employer with respect to such PHI; and

(ii) implement reasonable and appropriate security measures to protect such Electronic PHI.

(d) not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another HIPAA Health Plan;

(e) to report to the HIPAA Health Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures described in the Privacy Policy or any security incident of which the Employer becomes aware;

(f) to make available PHI for inspection and copying in accordance with 45 C.F.R. §164.524;

(g) to make available PHI for amendment, and to incorporate any amendments to PHI in accordance with 45 C.F.R. §164.526;

(h) to make available PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;

(i) to make its internal practices, books, and records relating to the use and disclosure of PHI received on behalf of a HIPAA Health Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Care Components with the Privacy Rule;

(j) if feasible, to return or destroy all PHI received from a HIPAA Health Plan that the Employer still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible;

(k) to take reasonable steps to ensure that there is adequate separation between the HIPAA Health Plan and the Employer's activities in its role as Plan sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

(l) to not use or disclose PHI that is Genetic Information about an individual for underwriting purposes.

8.6 Mitigation. In the event of non-compliance with any of the provisions set forth in this Article,

(a) the HIPAA Privacy and Security Official shall address any complaint promptly and confidentially. The HIPAA Privacy and Security Official first will investigate the complaint and document his or her investigation efforts and findings.

(b) if PHI has been used or disclosed in violation of the Privacy or Security Policy or inconsistent with this Article, the HIPAA Privacy and Security Official shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

(c) if an Authorized Employee or other Employer employee is found to have violated the Privacy or Security Policy, such personnel shall be subject to disciplinary action up to and including termination.

8.7 Breach Notification. Following the discovery of a Breach of unsecured PHI, the Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 C.F.R. §164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 C.F.R. §164.408. For Breach of unsecured PHI involving more than five-hundred (500) residents of a state or jurisdiction, the Plan shall notify the media in accordance with 45 C.F.R. §164.406.

8.8 Compliance with Part 2 (Federal Confidentiality Rules). In addition to compliance with HIPAA and state privacy and security laws, the Plan will also comply with Part 2, the federal Confidentiality of Substance Use Disorder Patient Records (42 C.F.R. Part 2) upon receipt of patient identifying information subject to Part 2. Disclosure and use of the information permitted under Part 2 shall be limited only to payment and/or health care operations activities. The Plan shall access the applicable notice under 42 C.F.R. §2.32; shall implement appropriate safeguards to prevent unauthorized disclosure and/or use; and shall report promptly any unauthorized disclosure and/or use to the Privacy Official. No redisclosure of information subject to Part 2 shall be made except to an agent of a business associate in compliance with 42 C.F.R. §2.33(c).

ARTICLE IX: SPECIAL COVERAGE PROVISIONS

9.1 COBRA and COBRA-like Continuation Coverage. This Article IX will only apply to Benefit Programs that would be considered a "group health plan" under Section 5000(b)(1) of the Code.

(a) Qualified Beneficiary. Only a "***Qualified Beneficiary***" (as defined by federal law) may elect to continue group health plan coverage under a "group health plan" Benefit Program as provided by COBRA due to a "qualifying event." For purposes of federal law, a "Qualified Beneficiary" includes a Covered Employee, a Covered Employee's Dependent child and/or Spouse who is a covered Dependent under a Benefit Program that is a group health plan subject to the requirements of COBRA on the day before a qualifying event, as provided in Code Section 4980B(g). "Qualified Beneficiary" will also mean a child who is born to or placed for adoption with the Participant during the period of COBRA continuation coverage, provided that such Participant notifies the Administrator in writing within thirty-one (31) days of the child's birth, adoption or placement for adoption. Although federal law does not extend COBRA continuation rights to Domestic Partners, the Plan extends these same continuation benefits to Domestic Partners of Covered Employees (and their children if not legal children of the Covered Employee) to the same extent they are provided to Spouses and legal Dependent children of the Covered Employee, and such individuals are hereby included in the definition of Qualified Beneficiary for purpose of this Article IX.

(b) Qualifying Events. A Qualified Beneficiary who would otherwise lose group health plan coverage due to a "qualifying event," as defined below, will be entitled to elect COBRA continuation of group health plan coverage under the applicable group health plan Benefit Program as provided by or under the same terms as COBRA. The coverage will be identical to the coverage provided persons to whom a qualifying event has not occurred. If coverage is modified for individuals who have not incurred a qualifying event, continuation coverage will be modified in the same way for individuals who have elected COBRA or COBRA-like continuation coverage (as applicable). A "qualifying event" is any of the following:

(i) termination of the Covered Employee as an Employee (other than for gross misconduct) or reduction of hours worked so as to render the Covered Employee ineligible for group health plan coverage under a Benefit Program, including termination of employment following a leave under FMLA;

(ii) the Covered Employee's death;

(iii) divorce or legal separation of the Covered Employee from his or her Spouse;

(iv) dissolution of a domestic partnership between a Covered Employee and his or her Domestic Partner as documented by a Notice of Dissolution of Domestic Partnership submitted to the Employer by the Covered Employee and his or her Domestic Partner.

(v) for a Spouse and Dependent children, loss of coverage due to the Covered Employee's becoming entitled to Medicare; or

(vi) for a Dependent child or Eligible Dependent of a Domestic Partner, ceasing to qualify as an eligible Dependent or Eligible Dependent of a Domestic Partner under the applicable Benefit Program.

To lose coverage means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event; provided that if coverage is reduced or eliminated in anticipation of an event (e.g., in anticipation of a divorce), then the reduction or elimination is disregarded in determining whether an event would cause a loss of coverage.

(c) Notice to Administrator. The Administrator may establish reasonable procedures for providing the notices required by this Article IX.

(i) A Covered Employee or his or her Qualified Beneficiary must notify the Administrator in writing within sixty (60) days after the later of:

1) the date of a divorce or legal separation or dissolution of Domestic Partnership or the date an eligible Dependent child will cease to qualify as an eligible Dependent under the applicable Benefit Program, or the date of a second qualifying event; or

2) the date coverage would be lost as a result of the event; or

3) the date on which the Qualified Beneficiary is informed of the responsibility to provide notice and the Plan's procedures for providing notice to the Administrator.

All rights to continued Benefit Program coverage will be lost by the failure to timely give this required written notice to the Administrator.

(ii) An eligible Participant may elect COBRA or COBRA like continuation coverage for an eligible child who is born to, adopted by, or placed for adoption with such Participant while the Participant's COBRA continuation coverage (or right to elect COBRA continuation coverage) is effective, provided that the Participant has notified the Administrator in writing within thirty-one (31) days of the child's birth, adoption, or placement for adoption.

(iii) An Employer will notify the Administrator of the following qualifying events within thirty (30) days of the event, or within thirty (30) days following the date coverage ends if the Benefit Program provides that continuation coverage commences on the date coverage is lost:

1) the Covered Employee's death;

2) termination or reduction in hours that the Covered Employee's works; or

3) the Covered Employee's becoming entitled to Medicare.

(iv) A Participant or Qualified Beneficiary entitled to COBRA or COBRA like continuation coverage with a maximum duration of eighteen (18) months will notify the Administrator, in writing, if found by the Social Security Administration to have been disabled at any time during the first sixty (60) days of continuation coverage. This written notice must be given within sixty (60) days after the later of:

1) the date of the disability determination by the Social Security Administration;

2) the date on which the qualifying event occurred;

3) the date on which the Participant or Qualified Beneficiary loses or would lose coverage under the Plan as a result of the qualifying event; or

4) the date on which the Participant or Qualified Beneficiary is informed of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Administrator;

provided, however, that the notice is received before the end of the first eighteen (18) months of COBRA or COBRA like continuation coverage.

(v) A Participant or Qualified Beneficiary who has been found to have been disabled (as described in Section 9.1(c)(iv)) will notify the Administrator, in writing, of a subsequent determination by the Social Security Administration that the individual is no longer disabled. This written notice must be provided within thirty (30) days after the later of:

1) the date of the final determination by the Social Security Administration that the disabled individual is no longer disabled; or

2) the date on which the disabled Participant or Qualified Beneficiary is informed of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Administrator.

(d) Notice to Participant and Qualified Beneficiary.

(i) The Administrator must advise each Participant and all Qualified Beneficiaries of the right to continue coverage not later than:

1) fourteen (14) days after being notified of a qualifying event, or

2) if the Employer is the Administrator, not later than forty-four (44) days after occurrence of the qualifying event or, if the Benefit Program provides that continuation coverage commences the date coverage is lost, not later than forty-four (44) days after the date coverage is lost.

(ii) If the Administrator receives a notice under Section 9.1(c) and the individual is not entitled to COBRA or COBRA continuation coverage (as applicable), the Administrator will provide notice to the individual that COBRA or COBRA like coverage is unavailable.

(iii) If the COBRA or COBRA like coverage terminates earlier than the end of the maximum period described in Section 9.1(g), then the Administrator will provide notice to each Participant and his or her Qualified Beneficiary of the date of termination (in accordance with applicable regulations) as soon as possible following the Administrator's determination that coverage will terminate.

(iv) Notice of the right to continued coverage to a Qualified Beneficiary Spouse or Domestic Partner will be deemed notice to any Qualified Beneficiary children residing with such Spouse or Domestic Partner. Notwithstanding the preceding sentence, a single notice addressed to a Participant and Spouse or Participant and Domestic Partner may be provided under this Article IX, provided that the most recent information available to the Administrator indicates that both reside at the same address. Each Qualified Beneficiary that is a covered Dependent child may be notified by providing a single notice to either the Participant or Spouse or Domestic Partner (as applicable), provided that the most recent information available to the Administrator indicates that the Dependent resides at the same address as the individual to whom notice was given. An election to receive or to waive coverage for a Dependent child may be made by the Participant or his or her Spouse or his or her Domestic Partner with whom the Dependent child resides.

(e) Election of Coverage. If the Qualified Beneficiary does not elect continuation coverage within the election period set forth in this paragraph, then the right to continuation coverage based on COBRA rules or application of COBRA-like rules will be lost. Coverage must be elected within sixty (60) days of the latest of the following:

(i) the qualifying event; or

(ii) the date the Participant or Qualified Beneficiary is advised by the Administrator of the right to continued coverage.

(f) Payment for Coverage.

(i) The Participant and/or Qualified Beneficiary will be required to pay up to 102% of the group rate for the continued coverage as determined by the Administrator and have the option to make these payments in monthly installments. Such monthly installment payments

are due by the thirtieth (30th) day after the first day of the month for which payment is made. Installments that are paid later than such thirty (30) day grace period will not be deemed timely and will result in coverage being terminated.

(ii) Contribution amounts and benefits for continuation coverage are subject to change. The Participant or Qualified Beneficiary, as applicable, will be notified of any changes in contribution amounts or benefits available under the applicable Benefit Program.

(iii) If the Participant or Qualified Beneficiary elects COBRA continuation coverage after the qualifying event, then the Participant or Qualified Beneficiary will have forty-five (45) days from the date of election to start paying for that coverage. The first payment must include the cost of coverage for the entire period from the date coverage was lost due to the qualifying event at least through the date of payment. There is no grace period for the first payment. Subsequent monthly installment payments are due by the thirtieth (30th) day after the first day of the month for which payment was late. Installments that are paid after such thirty (30) day grace period will not be deemed timely and will result in COBRA or COBRA-like coverage being terminated.

(iv) The Benefit Program will not be required to bill covered individuals for continuation coverage. If any payment for continuation coverage is postmarked or otherwise sent after the date that payment is due, continuation coverage under the Benefit Program will terminate and will not be reinstated. An exception will be made for "insignificant underpayment" of a monthly installment. A payment will be deemed an insignificant underpayment provided that the deficiency is no greater than the lesser of:

1) $50 or such other amount as the Internal Revenue Service Commissioner may provide; or

2) 10% of the installment amount due.

In such a case, the Plan will notify the Participant or Qualified Beneficiary, as applicable, of the deficiency, and the Participant or Qualified Beneficiary will have thirty (30) days from the date of such notice to pay the deficiency.

(g) Period of Coverage.

(i) If elected, the maximum period for continued coverage is as follows:

1) Eighteen (18) months from the date coverage is lost due to a qualifying event involving termination of employment or reduction in hours; and

2) Thirty-six (36) months from the date coverage is lost on account of any other qualifying event.

(ii) The maximum period described in subparagraph (i)(1) may be extended if:

1) COBRA or COBRA-like continuation coverage is triggered by the Covered Employee's termination of employment or reduction in hours and either the Covered Employee or Qualified Beneficiary is found by the Social Security Administration to have been disabled at any time during the first sixty (60) days of continuation coverage, then the disabled person and his or her covered family members will be eligible for up to twenty-nine (29) months of continued coverage (an additional eleven (11) months). The Administrator may assess an increased charge of up to 150% of the cost of Benefit Program coverage for the additional eleven (11) months of coverage; or

2) If a second qualifying event that gives rise to a thirty-six (36) month maximum coverage period occurs within the applicable eighteen (18) or twenty-nine (29) month period, the period of coverage may be extended up to thirty-six (36) months from the date of the first qualifying event for the Covered Employee's Qualified Beneficiary Spouse, Child, Domestic Partner and Domestic Partner's Child. This extended coverage period will be available when one of the following events occurs during such original period of continued coverage:

A. the Covered Employee's death;

B. divorce or legal separation of the Covered Employee from his or her Qualified Beneficiary Spouse; or

C. dissolution of a domestic partnership between a Covered Employee and his or her Domestic Partner as documented by a Notice of Dissolution of Domestic Partnership submitted to the Employer or Participating Employer by the Covered Employee and his or her Domestic Partner; or

D. for a Qualified Beneficiary Child, or Eligible Dependent of a Domestic Partner, ceasing to qualify as an eligible Dependent under the applicable Benefit Program.

To be eligible for this additional coverage, the Covered Employee or his or her qualified beneficiary must notify the Administrator in writing within sixty (60) days of the second qualifying event and before the applicable eighteen (18) or twenty-nine (29) month period of continued coverage ends.

(iii) Coverage will end before the end of the maximum period on the first of the following, if any, to occur:

1) the date all Employers cease to provide any group health plan coverage to any Employee;

2) the date the Participant or Qualified Beneficiary fails to make any required installment contribution payment;

3) the date that there has been a final determination by the Social Security Administration that the Participant or Qualified Beneficiary who has elected to extend coverage for up to twenty-nine (29) months due to disability is no longer disabled;

4) the date the Employer terminates the Employee's coverage for cause (for example, submission of a fraudulent claim by the Employee); or

5) the first day after the Participant or Qualified Beneficiary makes a COBRA election on which the Participant or qualified beneficiary becomes:

A. a covered employee or dependent under any other group health plan other than TRICARE or any other government-sponsored medical care program while that person is on a Leave of Absence under USERRA; or

B. entitled to Medicare.

However, if the Participant or qualified beneficiary becomes covered by another group health plan and has a pre-existing condition that is not covered by such other plan, then COBRA or COBRA-like coverage (at least for that pre-existing condition) will not be terminated due to such other coverage.

(iv) COBRA continuation coverage is provided subject to eligibility under the law. The Administrator reserves the right to terminate COBRA continuation coverage retroactively if the individual is determined to be ineligible for COBRA continuation coverage. The Administrator intends to provide COBRA continuation coverage only to the extent required by law and will administer COBRA continuation coverage according to those requirements. This Section will not create any rights in excess of the minimum required by law.

(h) Health Care Spending Account. Notwithstanding any provision in the Plan to the contrary, COBRA continuation coverage as provided in this Section will not be provided under the Health Care Spending Account:

(i) for any Plan Year after the Plan Year in which the qualifying event occurs, with respect to any Participant or covered Dependent, as long as:

1) the benefits under the Health Care Spending Account are excepted benefits within the meaning of Sections 9831 and 9832 of the Code; and

2) the cost of twelve (12) months of COBRA continuation coverage under the Health Care Spending Account for the Plan Year in which the qualifying event occurs equals or exceeds the maximum benefit available to the Participant or covered Dependent under the Health Care Spending Account for the Plan Year; and

(ii) for the Plan Year in which the qualifying event occurs, if as of the date of the qualifying event, such Participant or covered Dependent cannot become entitled to receive during the remainder of such Plan Year a benefit under the Health Care Spending Account that exceeds the maximum amount that the Participant or covered Dependent must pay for COBRA continuation coverage for the remainder of such Plan Year. For purposes of this item, in determining the amount of the benefit under the Health Care Spending Account that the Participant or covered Dependent can become entitled to receive during the remainder of the Plan Year in which the qualifying event occurs, the Health Care Spending Account may deduct from the maximum benefit available to the Participant any reimbursable claims submitted to the Health Care Spending Account before the date the qualifying event occurred.

(i) Continuation Coverage After Relocation. If a Participant or Qualified Beneficiary relocates to an area not served by his or her region-specific health coverage benefit program or option, the Participant or Qualified Beneficiary will be given, within a reasonable period of time after requesting other coverage, an opportunity to elect alternative or extended coverage if there is another program or option available to Participants who have not experienced a qualifying event that will serve the Participant's or Qualified Beneficiary's health care needs. The alternative coverage must be effective as of the later of the date of the Participant's or Qualified Beneficiary's relocation, or the first of the month following the month in which the alternative coverage is requested.

(j) Annual Enrollment. In the event that an annual enrollment occurs during a period of COBRA or COBRA-like continuation coverage, the affected Participant or Qualified Beneficiary will be given the same right that is provided to active Employees to choose other coverage or another benefit option under a group health plan under which he or she would otherwise be entitled to coverage under this Section.

9.2 Other Health Coverage Alternatives. There are health coverage options available other than under COBRA. Other coverage may be available for purchase through the Health Insurance Marketplace, Medicaid, or other group health plan options (such as a Spouse's plan). Eligibility for COBRA does not limit eligibility for coverage through these other health coverage

options. Additionally, special enrollment opportunities for another group health plan (such as a Spouse's plan), may be available even if the plan generally does not accept late enrollees.

9.3 Conversion of Coverage. Unless the Program Documents provide otherwise, the Plan will not provide conversion coverage; provided, however, that nothing in a Benefit Program will preclude a Participant from exercising any conversion option made available to him or her by an insurance company under an insurance company contract. Unless the Program Documents provide otherwise, neither the Administrator nor any Employer will have any obligation to provide notice of any such conversion option.

9.4 Required Coverage. Notwithstanding anything contained in any Program Document to the contrary, the following provisions will apply to each Group Health Plan component Benefit Program:

(a) Minimum Hospital Stay. To the extent required by the Newborns' and Mothers' Health Protection Act of 1996, as amended from time to time, each Benefit Program may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, the Benefit Program may not, under federal law, require that any provider obtain authorization from the Benefit Program for prescribing a length of stay not in excess or forty-eight (48) hours (or ninety-six (96) hours). A Benefit Program may require, as a condition of the Participant reducing his or her out-of-pocket costs, a Participant to notify it in advance of a hospital admission in connection with a childbirth. This Section will not create any rights in excess of the minimum required by law.

(b) Mental Health Benefits and Substance Use Disorders. To the extent required by the Mental Health Parity and Addiction Equity Act of 2008, as amended from time to time, each Benefit Program subject to that act will provide the same level of benefit and benefit limitations on coverage for mental health or substance use disorders as the benefit and benefit limitations provided by the Benefit Program for general medical treatment. Nothing in the Plan will be construed to require any Benefit Program to provide coverage for mental health benefits or substance use disorders. This Section will not create any rights in excess of the minimum required by law.

(c) Benefits for Reconstructive Surgery Following Mastectomy. To the extent required by the Women's Health and Cancer Rights Act of 1998, as amended from time to time, each Benefit Program subject to that act will provide coverage to a Participant or Dependent who elects breast reconstruction in connection with a mastectomy for (i) all stages of reconstruction of the breast in which the mastectomy was performed; (ii) surgery and reconstruction of the

other breast to produce symmetrical appearance; and (iii) prostheses and physical complications of mastectomy, including lymphedemas. Such coverage will be provided in a manner determined in consultation with the treating physician and Participant or Dependent. This Section will not create any rights in excess of the minimum required by law.

(d) Coverage During FMLA Leave. A Participant on a leave of absence that qualifies as leave under the Family and Medical Leave Act of 1993 ("FMLA") may continue to receive group health plan coverage under this Plan during such leave along with his or her eligible Dependents as if such participant did not experience an interruption in active employment until the end of such FMLA leave period, or, if earlier, the date the Participant gives notice that he or she does not intend to return to work at the end of the FMLA period. The Participant must make any required contributions for group health plan coverage during such period in such time and manner as the Administrator may require under applicable federal regulations and in accordance with the terms of any applicable Code Section 125 cafeteria plan sponsored by the Employer. If a Participant does not continue group health coverage or other types of coverage but returns to work before the expiration of FMLA leave, he or she will be reinstated in his or her benefit coverage, including group health care coverage, at the same level and under the same conditions as if the leave had not occurred.

(e) Military Leave. A Participant's right to elect continued participation in a group health plan available under this Plan for himself or herself, the Participant's Spouse and Dependents during a leave of absence for active military duty is protected under USERRA.

(i) Participants may elect to continue group health plan coverage under the Plan for a period of time that is the lesser of:

(A) the 24-month period beginning on the Participant's first day of military leave, or

(B) the period beginning on the Participant's first day of military leave and ending on the date the Participant fails to return from military leave or apply for re-employment as required under USERRA.

(ii) If a Participant's absence for military duty is less than 31 days, the Participant will be required to pay the regular employee share of the cost for group health plan coverage. If the Participant's absence is for 31 or more days, the Participant will be required to pay not more than 102% of the full cost of the group health plan coverage (and the Participant's Spouse and Dependents) under the Plan.

(iii) USERRA continuation group health plan coverage is considered alternative group health plan coverage for purposes of COBRA. Therefore, if a Participant elects USERRA continuation coverage, COBRA continuation group health plan coverage shall not be available.

(iv) Participants returning from military leave shall be reinstated upon re-employment, and any exclusion or waiting period shall not be imposed if such exclusion or waiting period would not have been imposed had the Participant's coverage not been terminated due to military leave. This paragraph shall not apply to illnesses or injuries determined by the Secretary of Veteran's Affairs or his or her representative to have been incurred in, or aggravated during, the performance of military service.

(v) In no event shall benefits available under this Plan during a period of USERRA qualified military leave be less generous than those benefits available during other comparable employer approved leave periods (e.g., family and medical leave).

Schedule 1

GENERAL INFORMATION ABOUT THE BARNES GROUP INC. HEALTH AND WELFARE PLAN

This Schedule 1 contains certain general information which Participants may need to know about the Plan. For certain Benefit Programs, this section is intended to supplement the information contained in the Certificates of Coverage, participant booklets and benefit summaries of the component Benefit Programs.

1. General Plan Information

Plan Name:	The Barnes Group Inc. Health and Welfare Plan
Plan Number:	The Employer has assigned Plan Number 518 to the Plan
Effective Date:	The Plan is amended and restated effective as of January 1, 2021.
Plan Year:	The Plan's records are maintained on a twelve (12) month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

2. Employer Information

The Employer's name, address, and identification number are:

Barnes Group Inc.
123 Main Street
Bristol, CT 06010

EIN # 06-0247840

3. Administrator Information

The name, address and business telephone number of the Plan's Administrator are:

Senior Vice President, Human Resources
Barnes Group Inc.
123 Main Street
Bristol, CT 06010

Telephone: (860) 583-7070

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. Participants should contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

National Registered Agents, Inc.
12 Old Boston Post Road
Old Saybrook, CT 06457

5. Type of Administration

Plan administration is based on a combination of administration provided by the Group Benefit Plan providers, the Employer and Participating Employers.

6. Claims Submission - Claims Administrator

Claims for expenses should be submitted pursuant to the Employer's procedures or, if applicable, the applicable Group Benefit Program Provider's procedures for the applicable Benefit Programs in which the Participant is enrolled. Participants may also obtain forms from the Benefits Department.

ADDITIONAL PLAN INFORMATION

Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

(a) examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, 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.

(b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies.

(c) continue health coverage for a Participant, spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.

(d) review the summary plan description, the documents governing the plan and the rules governing COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of Plan Participants.

No one, including the employer or any other person, may fire or otherwise discriminate against an employee in any way to prevent the employee from obtaining a benefit or exercising rights under ERISA.

If a claim for a benefit is denied or ignored, in whole or in part, the participants has 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.

If a claim for benefits is denied or ignored, in whole or in part, a participant may file suit in a state or Federal court. In addition, if the participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the participant may file suit in Federal court.

Under ERISA there are steps to take to enforce the above rights. For instance, if a participant requests materials from the Plan and does not receive them within thirty (30) days, the participant may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay up to $110 a day until receipt of the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If a participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if a participant is discriminated against for asserting his or her rights, the participant may seek assistance from the U.S. Department of Labor, or file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay these costs and fees. If the participant loses, the court may order him or her to pay these costs and fees; for example, if it finds the claim to be frivolous.

If there are any questions about the Plan, the participant should contact the Administrator. If the participant has any questions about this statement, or about rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if assistance is needed in obtaining documents from the Administrator, the participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Certain publications about a participant's rights and responsibilities under ERISA can

be obtained by calling the publications hotline of the Employee Benefits Security Administration (1-866-444-3273).

Schedule 2

CLAIMS ADMINISTRATION

BARNES GROUP INC. HEALTH AND WELFARE PLAN

All claims for benefits under the Plan shall be submitted to and decided by such persons or organizations as the Administrator may from time to time designate, in the form and within the time specified by the Administrator. The Administrator may delegate its authority and responsibilities under this Schedule 2 to a Claims Administrator, provided such delegation is in writing. Any reference to the Administrator in this Claims Procedure shall mean the applicable Claims Administrator if the relevant authority and responsibility has been delegated by the Administrator to that Claims Administrator. The Administrator has sole discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan shall be paid only if the Administrator decides in its sole discretion that the Claimant is entitled to them. The Administrator's decisions made pursuant to this Section are intended to be final and binding on Participants, Dependents, beneficiaries and others.

Applicable Procedures. To the extent a Benefit Program does not independently provide claims procedures and administration, the claims administration process set forth in this Claims Procedure shall apply. For all Health Care Claims, the expedited claims procedures set forth in Section 1 shall apply. For disability claims, the claims procedures set forth in Section 2 shall apply. For all other claims (including claims relating to eligibility) filed under the Plan, the claims procedures set forth in Section 3 shall apply. If a Benefit Program provides a second level of appeal or the claim relates to eligibility, Section 3 shall apply. All notices required to be provided under these claims procedures shall be in writing and shall be culturally and linguistically appropriate in accordance with 26 C.F.R. §54.9815-2719T(b)(2)(ii)(E).

Notwithstanding any other provision to the contrary, to the extent that the Administrator properly delegates its claims authority to a Claims Administrator, the Claims Administrator may apply alternative time frames than that set forth in this Schedule 2. In such circumstance, such alternative time frames shall control. In any case, each claims procedure set forth in this Schedule 2 or applied by the Claims Administrator is intended to comply with Department of Labor Regulations Section 2560.503-1 and Section 1001(5) of the ACA regarding internal and external claims procedures, including the regulations that may be issued from time to time thereunder.

Insured Programs. Notwithstanding any provision of the Plan to the contrary, to the extent that an insurance company (or other Claims Administrator) administers claims under a Benefit Program, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company. The insurance company shall determine claims related to eligibility only to the extent eligibility depends on an insurance requirement such as evidence of insurability. In such case, the insurance company or other Claims Administrator shall be the "named fiduciary" for purposes of such Benefit Program, as permitted under Department of Labor Regulations Section 2560.503-1(g).

Processing of Claims. Unless a Benefit Program provides for a shorter period, all claims must be submitted within one (1) year after the date the claim accrues. The Administrator shall process a claim promptly after it receives complete written proof of the claim. The Administrator may process an Urgent Care Claim without a complete written proof of claim, provided that any benefit paid is conditioned upon the Administrator receiving a complete written proof of claim within a reasonable period of time thereafter. If the Administrator finds that benefits are payable under the Plan, it shall send payment to the Claimant, unless such individual authorizes payment to be made directly to the provider of services or supplies. Notwithstanding the foregoing, the Plan shall provide continued coverage pending the outcome of an appeal in accordance with 26 C.F.R. § 54.9815-2719T(b)(2)(iii).

Section 1 – Internal Review of Health Care Claims.

Definitions. For purposes of this Schedule 2, the following definitions shall apply:

"***Claimant***" means and individual who submits a written claim to the Administrator pursuant to these Claims Procedures.

"***Concurrent Care Claim***" means a Health Care Claim to extend an ongoing course of treatment beyond the period of time or number of treatments authorized by the Administrator.

"***Health Care Claim***" means a request by a Claimant for a benefit under a Benefit Program that is a group health plan (i.e., an employee welfare benefit plan within the meaning of ERISA Section 3(1) to the extent that such plan provides "medical care" within the meaning of ERISA Section 733(a)) that is made in accordance with the rules and procedures established by the Administrator.

"***Post-Service Claim***" means a Health Care Claim that is not a Pre-Service Claim, Urgent Care Claim or Concurrent Care Claim.

"***Pre-Service Claim***" means a Health Care Claim with respect to which the terms of a Benefit Program condition receipt of the benefit, in whole or in part, on approval of the benefit in advance by the Administrator in advance of obtaining medical care.

"***Urgent Care Claim***" means a Health Care Claim for medical care not yet performed but, if delayed:

(a) could seriously jeopardize the Claimant's life, health or the ability to regain maximum function; or

(b) in the opinion of a physician who has knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or medical treatment for which the Claimant is filing the claim.

Time Limits for Initial Claims. Any person who believes that he or she is then entitled to receive a health care benefit under the Plan, including one greater than that initially determined by the Administrator, may file a Health Care Claim in writing with the Administrator. The Administrator shall notify a Claimant of its benefits determination, depending on the type of claim, within a specific time period, as set forth in this subsection.

Urgent Care Claim: The Administrator shall provide notice of the Plan's benefit determination to a Claimant as soon as possible, taking into account medical exigencies, but no later than twenty-four (24) hours after the Plan receives an Urgent Care Claim. However, if the Claimant does not provide sufficient information with a claim the Administrator shall notify the Claimant of the deficiency as soon as possible, but not later than twenty-four (24) hours after receiving the claim. Such notice shall describe the proper claims procedure and/or the specific information necessary to complete the Urgent Care Claim. If an Urgent Care Claim is incomplete or the Administrator requires more information, a Claimant shall have at least 48 hours to provide the specified information. In the case of an incomplete initial claim, the Administrator shall notify a Claimant of its benefits determination no later than forty-eight (48) hours after the earlier of:

(a) the time the Administrator receives the specified information; or

(b) the end of the period in which a Claimant was allowed to provide the required information.

Pre-Service Claim (Not Involving An Urgent Care Claim): The Administrator shall notify a Claimant of the Plan's benefit determination within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days after the Administrator receives a Pre-Service Claim. The Administrator may extend this fifteen (15) day period one time for up to fifteen (15) days, if the Administrator determines that more time is necessary due to matters beyond the Plan's control. The Administrator shall notify a Claimant before the end of the initial fifteen (15) day period if an extension is necessary. If the extension is necessary because a Claimant did not submit required information, the Administrator shall, in the notice, specifically describe the required information and shall provide the Claimant with an additional forty-five (45) days to provide the information. In this case, the time period allowed for making the benefits determination is tolled from the date the notice is sent to the Claimant until the date the Claimant responds to the notice. If the Claimant does not follow the Plan's claims procedure, the Administrator shall notify the Claimant as soon as possible, but not later than five (5) calendar days after receiving the Pre-Service Claim. The notice will describe the proper procedure for filing the Pre-Service Claim.

Concurrent Care Claim: For a Concurrent Care Claim relating to Urgent Care, the Administrator shall notify a Claimant as soon as reasonably possible, taking into account the medical exigencies, but generally no later than twenty-four (24) hours after the Concurrent Care Claim relating to Urgent Care is received, provided that any such claim is made to the Plan at least twenty-four (24) hours before the prescribed period of time or number of treatments

expires. For a Concurrent Care Claim relating to non-Urgent Care, the Administrator shall notify a Claimant sufficiently in advance of the reduction or termination of the Claimant's treatment to allow a Claimant to appeal and obtain a review of the Concurrent Care Claim before the treatment is reduced or terminated.

Post-Service Claim: The Administrator shall notify a Claimant of the Plan's benefit determination not later than thirty (30) days after the Administrator receives a Post-Service Claim. If the Administrator determines that more time is necessary due to matters beyond the Plan's control, the Administrator may extend this thirty (30) day period one time, for up to fifteen (15) days. The Administrator shall notify a Claimant before the end of the initial thirty (30) day period if an extension is necessary. If the extension is necessary because a Claimant did not submit required information, the Administrator shall, in the notice, specifically describe the required information and shall provide a Claimant with an additional forty-five (45) days to provide the information. In this case, the time period allowed for making the benefits determination is tolled from the date the notice is sent to a Claimant until the date the Claimant responds to the notice.

Notice of Initial Denial. The Administrator's denial of a claim (including the denial of a claim regarding a rescission of coverage) shall be written in a manner calculated to be understood by the Claimant and shall include:

(i) the specific reason or reasons for the benefit determination;

(ii) references to the specific Plan provisions on which the benefit determination is based;

(iii) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) 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 Claimant's claim;

(v) an explanation of the appeal procedure;

(vi) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy shall be furnished (free of charge) upon request;

(vii) if the decision was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to the Claimant's medical circumstances, or a statement that such an explanation shall be provided free of charge upon request; and

(viii) a statement that the Claimant has the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

Claimant's Right to Appeal. A Claimant (or his or her duly authorized representative) whose claim is denied in whole or in part by the Administrator (within one-hundred-eighty (180)) days after receipt of denial of his or her claim or, if no notice of denial was received, within one-hundred-eighty (180) days of the date the notice should have been provided):

(i) may submit a written request for review by the Administrator;

(ii) shall, upon request, receive reasonable access to, copies (free of charge) of all documents, records and other information relevant (within the meaning of Department of Labor Regulation Section 2560.503-1(m)(8)) to the Claimant's claim; and

(iii) may submit written comments, documents, records and other information relating to the claim for benefits.

In addition, the Plan must allow Claimants to review the claim file and present evidence and testimony as part of the claims and appeals process. The Plan also will provide the Claimant, free of charge, with (1) any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim; and (2) new or additional rationale, before the Plan can issue a final adverse benefit determination based upon such rationale.

Independent Review. The review of the initial decision concerning a Claimant's claim shall be performed by someone who is neither the original decision maker nor the subordinate of the original decision maker. In reviewing the initial decision, the decision maker shall not give any deference to the initial decision and he shall consider all information relevant to the claim, not just information relied upon (or available) when the original decision was made, including all comments, documents, records, and other information submitted by the Claimant relating to the claim.

If the benefit determination is based in whole or in part on a medical judgment, the decision maker reviewing the claim shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment issue; provided that such health care professional shall be an individual who is neither an individual who was consulted in connection with the initial claim denial that is the subject of the appeal nor the subordinate of any such individual. The Plan shall disclose to the Claimant the identity of medical or vocational experts whose advice was obtained by the Plan in connection with the review, even if the advice was not relied upon in making the final decision.

Time Limits for Decision on Appeal. The Administrator shall furnish the Claimant with a written decision providing the final decision concerning the claim as soon as practicable from the date of the request for appeal was submitted, but not later than:

a) seventy-two (72) hours (thirty-six (36) hours in the event the Administrator offers two (2) levels of appeal) after receipt of the Claimant's request for review of an Urgent Care Claim benefit determination;

b) thirty (30) days (fifteen (15) days in the event the Administrator offers two (2) levels of appeal) after receipt by the Plan of the Claimant's request for review of a Pre-Service Claim benefit determination; or

c) sixty (60) days (thirty (30) days in the event the Administrator offers two (2) levels of appeal) after the receipt by the Plan of the Claimant's request for review of a Post-Service Claim benefit determination.

Notice of Decision on Appeal. The decision concerning an appeal of a claim shall be written in a manner calculated to be understood by the Claimant and shall include:

(i) the specific reason or reasons for the benefit determination;

(ii) references to specific Plan provisions on which the benefit determination is based;

(iii) 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 Claimant's claim;

(iv) an explanation of any voluntary appeal procedures offered by the Plan, if any;

(v) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy shall be furnished (free of charge) upon request;

(vi) if the decision was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to the Claimant's medical circumstances, or a statement that such an explanation shall be provided free of charge upon request; and

(vii) a statement that the Claimant has the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

Notwithstanding the foregoing, Claimants may not seek benefits under the Plan in judicial, administrative proceedings or external review under Section 4 without first complying with and fully exhausting the procedures set forth in this Section 1. However, if the Plan fails to adhere to all requirements of 26 C.F.R. §54.9815-2719T(b)(2) with respect to a claim, then the Claimant is deemed to have exhausted the procedures set forth in Section 1. In addition, all such actions must be brought within one-hundred-eighty (180) days of receiving the Administrator's notice of denial or, if no notice of denial was received, within one-hundred-eighty (180) days of

the date the notice should have been provided. The decisions made pursuant to this Section 1 shall be final and binding on Claimants and any other party. If the Claimant has complied with and exhausted the appropriate claims procedures and intends to exercise his or her right to bring civil action under ERISA Section 502(a), the Claimant must bring such action within twelve (12) months following the date on which the Claimant is notified of the Administrator's final decision on appeal. If the Claimant does not bring such action within such twelve (12) month period, the Claimant shall be barred from bringing an action under ERISA related to his or her claim.

Section 2 – Internal Review of Disability Claims.

Time Limits for Initial Claims. Any person who believes that he or she is then entitled to receive a disability benefit under the Plan, including one greater than that initially determined by the Administrator, may file a claim in writing with the Administrator. The Administrator (or his or her designee) shall, within forty-five (45) days of the receipt of a claim, either grant or deny the claim in writing. An extension of thirty (30) days will be allowed for processing the claim if necessary due to matters beyond the Plan's control and the Claimant receives notice of such extension before the expiration of the initial forty-five (45) day period. The notice shall state the special circumstances involved and the date a decision is expected. If, before the end of the first thirty (30) day extension period, the Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional thirty (30) days, provided the Administrator notifies the Claimant before the expiration of the first thirty (30) day extension period of the circumstances requiring the additional extension and the date as of which the Plan expects to render a decision. If additional information is requested to resolve the issues, the time period allowed for making the benefits determination is tolled from the date the notice is sent to a Claimant until the date the Claimant responds to the notice.

Notice of Initial Denial. The Administrator's denial of a claim shall be written in a manner calculated to be understood by the Claimant and shall include:

(i) the specific reason or reasons for the benefit determination;

(ii) references to the specific Plan provisions on which the benefit determination is based;

(iii) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) 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 Claimant's claim;

(v) an explanation of the appeal procedure;

(vi) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy shall be furnished (free of charge) upon request;

(vii) an explanation for disagreeing with or not following the views of: (1) the health care professionals treating the Claimant and vocational professionals who evaluated the Claimant; (2) the views of the medical or vocational professionals who evaluated the Claimant, and; (3) any disability determinations made by the Social Security Administration;

(viii) if the decision was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to the Claimant's medical circumstances, or a statement that such an explanation shall be provided free of charge upon request; and

(ix) a statement that the Claimant has the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

The notification will be provided in a culturally and linguistically appropriate manner, (within the meaning of Department of Labor Regulation Section 2560.503-1(o)).

Claimant's Right to Appeal. A Claimant (or his or her duly authorized representative) whose claim is denied in whole or in part by the Administrator (within sixty (60) days after receipt of denial of his or her claim or, if no notice of denial was received, within sixty (60) days of the date the notice should have been provided):

(i) may submit a written request for review by the Administrator;

(ii) shall, upon request, receive reasonable access to, copies (free of charge) of all documents, records and other information relevant (within the meaning of Department of Labor Regulation Section 2560.503-1(m)(8)) to the Claimant's claim; and

(iii) may submit written comments, documents, records and other information relating to the claim for benefits.

In addition, the Plan must allow Claimants to review the claim file and present evidence and testimony as part of the claims and appeals process. The Plan also will provide the Claimant, free of charge, with (1) any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim; and (2) new or additional rationale, before the Plan can issue a final adverse benefit determination based upon such rationale.

Independent Review. The review of the initial decision concerning a Claimant's claim shall be performed by someone who is neither the original decision maker nor the subordinate of the

original decision maker. In reviewing the initial decision, the decision maker shall not give any deference to the initial decision and he shall consider all information relevant to the claim, not just information relied upon (or available) when the original decision was made, including all comments, documents, records, and other information submitted by the Claimant relating to the claim.

If the benefit determination is based in whole or in part on a medical judgment, the decision maker reviewing the claim shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment issue; provided that such health care professional shall be an individual who is neither an individual who was consulted in the connection with the initial claim denial that is the subject of the appeal nor the subordinate of any such individual. The Plan shall disclose to the Claimant the identity of medical or vocational experts whose advice was obtained by the Plan in connection with the review, even if the advice was not relied upon in making the final decision.

Time Limits for Decision on Appeal. The Administrator shall furnish the Claimant with a written decision providing the final determination of the claim. The decision shall be issued as soon as reasonable after the date of the request for appeal was submitted, and usually within forty-five (45) days of the date in which the written appeal was submitted. The Administrator may take an additional forty-five (45) days to make this decision if special circumstances are present. The Administrator shall give the Claimant notice if this extension is necessary before expiration of the initial forty-five (45) day period. In no event shall such extension exceed a period of forty-five (45) days from the end of the initial forty-five (45) day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

Notice of Decision on Appeal. The decision concerning an appeal of a claim shall be written in a manner calculated to be understood by the Claimant and shall include:

(i) the specific reason or reasons for the benefit determination;

(ii) references to the specific Plan provisions on which the benefit determination is based;

(iii) an explanation for disagreeing with or not following the views of: (1) the health care professionals treating the Claimant and vocational professionals who evaluated the Claimant; (2) the views of the medical or vocational professionals who evaluated the Claimant, and; (3) any disability determinations made by the Social Security Administration;

(iv) 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 Claimant's claim;

(v) an explanation of any voluntary appeal procedures offered by the Plan, if any;

(vi) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy shall be furnished (free of charge) upon request;

(vii) if the decision was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to the Claimant's medical circumstances, or a statement that such an explanation shall be provided free of charge upon request; and

(viii) a statement that the Claimant has the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

The notification will be provided in a culturally and linguistically appropriate manner, (within the meaning of Department of Labor Regulation Section 2560.503-1(o)).

Notwithstanding the foregoing, Claimants may not seek benefits under the Plan in judicial, administrative proceedings or external review under Section 4 without first complying with and fully exhausting the procedures set forth in this Section 2. However, if the Plan fails to adhere to all requirements of 26 C.F.R. §54.9815-2719T(b)(2) with respect to a claim, then the Claimant is deemed to have exhausted the procedures set forth in Section 1. In addition, all such actions must be brought within one-hundred-eighty (180) days of receiving the Administrator's notice of denial or, if no notice of denial was received, within one-hundred-eighty (180) days of the date the notice should have been provided. The decisions made pursuant to this Section 2 shall be final and binding on Claimants and any other party. If the Claimant has complied with and exhausted the appropriate claims procedures and intends to exercise his or her right to bring civil action under ERISA Section 502(a), the Claimant must bring such action within twelve (12) months following the date on which the Claimant is notified of the Administrator's final decision on appeal. If the Claimant does not bring such action within such twelve (12) month period, the Claimant shall be barred from bringing an action under ERISA related to his or her claim.

Section 3 – Internal Review of all Other Claims.

Time Limits for Initial Claims. Any person who believes that he or she is then entitled to receive a benefit under the Plan, including one greater than that initially determined by the Administrator, may file a claim in writing with the Administrator. The Administrator may establish and maintain separate procedures for submitting eligibility claims that do not require a claim to be in writing. The Administrator (or his or her designee) shall, within ninety (90) days of the receipt of a claim, either grant or deny the claim in writing. An extension of ninety (90) days will be allowed for processing the claim if special circumstances are involved and the Claimant is notified of such extension before the expiration of the initial ninety (90) day period. The notice shall state the special circumstances involved and the date a decision is expected. If no notice is received during that period, the claim shall be deemed denied and the Claimant may request a review of the decision.

Notice of Initial Denial. The Administrator's denial of a claim shall be written in a manner calculated to be understood by the Claimant and shall include:

(i) the specific reason or reasons for the benefit determination;

(ii) references to specific pertinent Plan provisions on which the benefit determination is based;

(iii) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) 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 (within the meaning of Department of Labor Regulation 2560.503-1(m)(8)) to the Claimant's claim;

(v) an explanation of the appeal procedure; and

(vi) a statement that the Claimant has the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

Notwithstanding the foregoing, if the Administrator does not timely respond to a claim in writing, the claim shall be deemed denied.

Claimant's Right to Appeal. A Claimant (or his or her duly authorized representative) whose claim is denied in whole or in part by the Administrator (within sixty (60) days after receipt of denial of his or her claim):

(i) may submit a written request for review by the Administrator;

(ii) shall, upon request, receive reasonable access to, copies (free of charge) of all documents, records and other information relevant (within the meaning of Department of Labor Regulation Section 2560.503-1(m)(8)) to the Claimant's claim; and

(iii) may submit written comments, documents, records and other information relating to the claim for benefits.

In addition, the Plan must allow Claimants to review the claim file and present evidence and testimony as part of the claims and appeals process. The Plan also will provide the Claimant, free of charge, with (1) any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim; and (2) new or additional rationale, before the Plan can issue a final adverse benefit determination based upon such rationale.

Time Limits for Appeal. The Administrator shall furnish the Claimant with a written decision providing the final determination of the claim. The decision shall be issued as soon as reasonable after the date of the request for appeal was submitted, and usually within sixty (60) days of the date in which the written appeal was submitted. The Administrator may take an additional sixty (60) days to make this decision if special circumstances are present. The Administrator shall give the Claimant notice if this extension is necessary before termination of the initial sixty (60) day period. The notice shall state the special circumstances involved and the date a decision is expected. In no event shall such extension exceed a period of sixty (60) days from the end of the initial sixty (60) day period.

Notice of Appeal. The decision concerning an appeal of a claim shall be written in a manner calculated to be understood by the Claimant and shall include:

(i) the specific reason or reasons for the denial;

(ii) references to the specific Plan provisions on which the benefit determination is based;

(iii) 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 (within the meaning of Department of Labor Regulation 2560.503-1(m)(8)) to the Claimant's claim;

(iv) an explanation of the voluntary appeal procedures offered by the Plan, if any, and

(v) a statement that the Claimant has the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

Second Appeal. If the Benefit Program provides for a second level of appeal, the Claimant must submit a written request for review within one-hundred-eighty (180) days after receipt of denial of his or her first appeal. In connection with the second appeal, the Claimant can again review relevant documents and submit issues and comments in writing. The Claimant shall also have the right to request copies of all relevant documents (free of charge). The second appeal will be subject to the same standards and time limits that apply to the first appeal.

In the event the appeal procedures are exhausted, a voluntary level of appeal may be available if the following conditions are met:

(i) coverage was denied either because the service or supply is not medically necessary; or because it is considered experimental or investigational; and

(ii) the cost of the service or supply at issue for which the member would be financially responsible exceeds $500.

Exhaustion of Administrative Remedies. Claimants shall not be entitled to challenge the Administrator's determinations in judicial or administrative proceedings without first complying with the administrative claims procedures set forth in the applicable Benefit Program or under this Article, as appropriate. All such claims must be brought within the timeframes set forth above for the Claimant's type of claim. The decisions made pursuant to applicable administrative claims procedures are final and binding on the Claimant and any other party. If the Claimant has complied with and exhausted the appropriate claims procedures and intends to exercise his or her right to bring civil action under ERISA Section 502(a), the Claimant must bring such action within twelve (12) months following the date on which the Claimant is notified of the Administrator's final decision on appeal. If the Claimant does not bring such action within such twelve (12) month period, the Claimant shall be barred from bringing an action under ERISA related to his or her claim.

Incompetency. If any person entitled to payments under the Benefit Programs is a minor or under other legal disability or otherwise incapacitated so as to be unable to manage his or her financial affairs, or is otherwise incapable of giving a valid receipt and discharge for any payment, the following provision shall apply. If the payment is to be made by an insurance company, such payment shall be made in accordance with the terms of the contract under which such benefit is payable. If the payment is to be otherwise made, the Administrator, in its discretion, may direct that all or any portion of such payment be made:

(i) to such person;

(ii) to such person's legal guardian or conservator; or

(iii) to such person's spouse or to any other person, in any manner the Administrator considers advisable, to be expended for his or her benefit. The decision of the Administrator (or, where applicable, that of the insurance company) shall, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred shall operate as a complete discharge of the obligations of the Benefit Programs, the Employer, the Employers, the Administrator and any insurance company, with respect to such payment.

Section 4 – External Review of Claims

The Federal external review process established pursuant to this Section 4 and in accordance with 26 C.F.R. §54.9815-2719T(d) and Technical Release 2010-01 applies to any adverse benefit determination or final adverse benefit determination as defined in 26 C.F.R. §54.9815-2719T(a)(2), except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the Plan is not eligible for the external review process.

Standard External Review

Request for Standard External Review. The Plan shall allow a Claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request shall be filed by the first day of the fifth (5^{th}) month following the receipt of the notice. If the last filing date falls on a Saturday, Sunday, or Federal holiday, then the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Preliminary Review. Within five (5) business days following the date of receipt of the external review request, the Plan shall complete a preliminary review of the request to determine whether:

a) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

b) The adverse benefit determination or the final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;

c) The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process; and

d) The Claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan shall issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notification shall describe the information or materials needed to make the request complete and the Plan shall allow a Claimant to perfect the request for external review the four (4) month filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization. The Plan shall assign an independent review organization ("IRO") that is accredited by URAC or by similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan shall take action against bias and to ensure independence. Accordingly, the Plan shall contract with at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO shall not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between the Plan and an IRO shall provide the following:

a) The assigned IRO shall utilize legal experts where appropriate to make coverage determinations under the Plan.

b) The assigned IRO shall timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten (10) business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.

c) Within five (5) business days after the date of assignment of the IRO, the Plan shall provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information shall not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final initial adverse benefit determination. Within one (1) business day after making the decision, the IRO shall notify the Claimant and Plan.

d) Upon receipt of any information submitted by the Claimant, the assigned IRO shall, within one (1) business day, forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan shall not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one (1) business day after making such a decision, the Plan shall provide written notice of its decision to the Claimant and the assigned IRO. The assigned IRO shall terminate the external review upon receipt of the notice from the Plan.

e) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process applicable under 26 C.F.R. §54.9815-2719T(b) and under Section 2719 of the Public Health Service Act ("PHS Act"). In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

   i. The Claimant's medical records;

   ii. The attending health care professional's recommendation;

iii. Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, Claimant, or Claimant's treating provider;

iv. The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

v. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

vi. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or applicable law; and

vii. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this Section 4 to the extent the information and documents are available and the clinical reviewer or reviewers consider appropriate.

f) The assigned IRO shall provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for the external review. The IRO shall deliver the notice of final external review decision to the Claimant and the Plan.

g) The assigned IRO's decision notice shall contain:

i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the dates or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the reason for previous denial);

ii. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

iii. References to the evidence and documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

iv. A discussion of the principal reason or reasons for its decision, including the rational for its decision and any evidence-based standards that were relied on in making its decision;

v. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the Claimant;

vi. A statement that judicial review may be available to the Claimant; and

vii. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHS Act.

h) After a final external review decision, the IRO shall maintain records of all Claimants and notices associated with the external review process for six (6) years. An IRO shall make such records available for examination by the Claimant, the Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Reversal of Plan's Decision. Upon receipt of a notice of final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately shall provide coverage or payment (including authorizing or immediately paying benefits) for the claim.

Expedited External Review

Request for Expedited External Review. The Plan shall allow a Claimant to make a request for an expedited external review with the Plan at the time the Claimant receives:

a) An adverse benefit determination, if the adverse benefit determination involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal under 26 C.F.R. §54.9815-2719T would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

b) A final internal adverse benefit determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Preliminary Review. Immediately upon receipt of the request for expedited external review, the Plan shall determine whether the request meets the reviewability requirements set forth above for standard external review. The Administrator shall immediately send a notice that meets the standards set forth above for standard external review to the Claimant of its eligibility determination.

Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Administrator shall assign an IRO pursuant to the requirements set forth above for standard review. The Administrator shall provide or transmit all necessary documents and information considered in making the adverse

benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO shall review the claim de novo and is not bound by any decision or conclusions reached during the Plan's internal claims and appeals process.

Notice of Final Review Decision. The Plan's contract with the assigned IRO shall require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the standard external process above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO shall provide written confirmation of the decision to the Claimant and the Plan.

APPENDIX A

PARTICIPATING EMPLOYERS

The Wallace Barnes Employer

Synventive Molding Solutions, Inc. (Effective January 1, 2014)

Manner USA, Inc. (Effective July 1, 2014)

Priamus System Technologies, LLC (Effective July 1, 2016)

Foboha US, Inc. (Effective January 1, 2017)

Gammaflux Controls, Inc. (Effective January 1, 2018)

Industrial Gas Springs Inc. (Effective January 1, 2019)

APPENDIX B

INSURED BENEFIT PROGRAMS ISSUED BY GROUP BENEFIT PROVIDERS

Effective January 1, 2021, the following Insured Benefit Programs shall be treated as comprising the Plan pursuant to Section 1.3:

GROUP BENEFIT PROVIDERS		BENEFIT PROGRAMS
(a)	ACE American Insurance Company 436 Walnut Street Philadelphia, PA 19016	Business Travel Accident (AD&D)
(b)	Guardian Life Insurance Company of America P.O. Box 26100 Lehigh Valley, PA 18022-6100	Long Term Disability, Accidental Death & Dismemberment, and Life Insurance
(c)	Vision Services Plan (VSP) PO Box 385018 Birmingham, AL 35238-0518	Voluntary Vision Plan

Unless specifically noted otherwise, Group Benefit Providers are responsible for financing and administration of the underlying Benefit Program.

APPENDIX C

BENEFIT PROGRAMS FUNDED BY THE EMPLOYER

Effective January 1, 2021, the following Benefit Programs funded by the Employer and Participating Employers shall be treated as comprising the Plan pursuant to Section 1.3:

	GROUP BENEFIT ADMINISTRATORS	BENEFIT PROGRAMS
(a)	Meritain Health, Inc. P.O. Box 853921 Richardson, TX 75085-3921 (800) 925-2272	Medical Plan
(b)	CVS Caremark 2215 Sander Road, Suite 500 Northbrook, IL 60062 (800) 364-6331	Prescription Drug Plan
(c)	Guardian Life Insurance Company of America P.O. Box 26100 Lehigh Valley, PA 18022-6100	Dental Plan
(d)	Marsh & McLennon Agency/MMA Marketlink2300 Renaissance Boulevard King of Prussia, PA 19406	Eligibility/Enrollment Benefits Administrator Flexible Spending Accounts Administrator COBRA Administrator
(f)	(Regular Mail) HSA Bank P.O. Box 939 Sheboygan, WI 53082-0939 (Overnight Mail) HSA Bank 605 North 8th Street, Suite 320 Sheboygan, WI 53081	Health Savings Account
(g)	LifeWorks134 North LaSalle Street, Suite 2200 Chicago, IL 60602	Wellness Program
(h)	Life Works 134 North LaSalle Street, Suite 2200 Chicago, IL 60602	Employee Assistance Program
(i)	MetLaw (Hyatt Legal Plans, Inc.)	Voluntary Pre-Paid Legal Plan

	GROUP BENEFIT ADMINISTRATORS	BENEFIT PROGRAMS
	1111 Superior Avenue Cleveland, OH 44114-2407	