CROUSE HEALTH

Crouse Hospital

Welfare Benefits Plan

and

SUMMARY PLAN DESCRIPTION

Non-Union Employees

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974, as amended and summarizes the welfare benefits offered under the Crouse Hospital Welfare Benefits Plan.

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1. Introduction

Crouse Hospital Welfare Benefits Plan (the "**Plan**") is an employee welfare benefit plan maintained by Crouse Hospital ("**Crouse Hospital"**, the **"Company",** the **"Employer"** or the **"Plan Sponsor"**) for the benefit of its Eligible Employees, Spouses and Dependents.

Crouse Hospital fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason with the appropriate required notification requirements.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminates, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force.

Grandfathered Status under Health Care Reform Law
Crouse Hospital believes that the medical benefit options under the plan are considered "non-grandfathered health plans" under the Patient Protection and Affordable Care Act ("the Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. However, your health plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits and dependent coverage to age 26, and no cost-sharing on preventive care services. Questions regarding which protections apply to a non-grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, US Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Note: Health Care Reform applies only to the medical and prescription drug benefits that are being offered under the Plan.

The Plan is an employee welfare benefit plan within the meaning of § 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This document and its Attachments constitute the summary plan description for each of the component plans as required by ERISA § 102. Participants should read this entire Plan document, including all exhibits and/or attachments to ensure that all requirements and conditions of the Plan are fully understood.

The Plan is intended to qualify as a "cafeteria plan" under Internal Revenue Code § 125, and regulations issued shall be interpreted to accomplish that objective.

The purpose of the Plan is to provide Employees with the opportunity to choose among those benefits available to them under the Plan. All Eligible Employees are required to pay a portion of the premium for medical, vision and dental through pre-tax salary reduction. Eligible Employees have the opportunity to purchase supplemental life insurance for themselves, their Spouses and/or their Dependents, voluntary critical illness insurance or participate in the voluntary benefit program and are required to pay the full premium cost of coverage with post-tax dollars through payroll deduction.

Eligible Employees who elect to participate and contribute to the flexible spending account plan (including health care or dependent care spending accounts) fund your accounts with pre-tax salary reduction contributions.

The cost of your participation in benefit programs can be found in Attachment # 11.

Each of these component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description, benefit agreement, or another governing document prepared by the insurance company or third-party administrator. A copy of each booklet, summary or other governing document is addressed in this document as Attachment # 1 to # 10. Copies of all documents for the Plan,

including those provided by third party administrators have been previously made available to you. All documentation related to the Plan is on file with the Crouse Hospital Human Resources Department and can be provided to you with your written request.

Participant's Responsibilities
Each Participant shall be responsible for providing the Plan Administrator, the Plan Sponsor, or the insurance company with his or her current address. If required by the insurance company, each employee who is a Participant shall be responsible for providing the insurance company with the address of a covered spouse and each of his or her covered eligible dependents. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The insurance company, the Plan Administrator, and the Plan Sponsor shall have no obligation or duty to locate a Participant.

Federal Extensions Due to Coronavirus
The Federal government has declared a National Emergency lasting from March 1, 2020 through July 25, 2020 (Outbreak Period) due to the Coronavirus (COVID-19) pandemic. All group health plans, disability and other Employee welfare benefit plans subject to the Employee Retirement Income Security Act ("ERISA") or the Internal Revenue Code ("IRC") must disregard the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency or July 25, 2020 for all plan participants, beneficiaries or claimants in determining the following dates:

1. The 30-day or 60-day period to request special enrollment - Special Enrollment Periods.
2. The 60-day election period for COBRA continuation coverage - COBRA.
3. The date for making COBRA premium payments - COBRA.
4. The date for individuals to notify the plan of a qualifying event or determination of disability - Claim Procedures.
5. The date within which individuals may file a benefit claim under the plan's claims procedures - Claim Procedures.
6. The date within which claimants may file an appeal of an adverse benefit determination under the plan's claims procedure.
7. The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination – Claim Denial and Appeal.
8. The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete – Claim Denial and Appeal.

The agencies of the Federal government will continue to monitor the effects of the Outbreak and may provide additional relief as warranted.

See the Human Resources Department for more information related to the Coronavirus Outbreak, the COVID-19 National Emergency, and/or any special leave provisions.

2. General Information About the Plan

Plan Name: Crouse Hospital
Welfare Benefits Plan

Type of Plan: Health and Welfare Benefits Plan

Plan Administrator Telephone Number: 315-470-7111

ERISA Plan Year: January 1st to December 31st

Plan Number: 504

Plan Sponsor: Crouse Hospital
736 Irving Avenue
Syracuse, NY 13210

Plan Administrator: Director of Human Resources
Crouse Hospital
736 Irving Avenue
Syracuse, NY 13210

Agent for Service of Legal Process: Director of Human Resources
Crouse Hospital
736 Irving Avenue
Syracuse, NY 13210

Plan Sponsor's Employer Identification Number: 16-0960470

Funding Medium and Type of Plan Administration:

The following benefits under the Plan are fully insured through insurance contracts:

Vision:	Davis Vision
Life and AD&D Insurance:	Symetra
Short Term Disability Insurance:	CIGNA
Long Term Disability Insurance[1]:	CIGNA
Supplemental Life Insurance for Employees, Spouses and Dependents:	CIGNA
Short Term Disability Insurance (NY – DBL):	CIGNA
Voluntary Critical Illness:	The Farmington Company
Voluntary Benefit Program:	The Farmington Company

Insurance premiums for employees and their eligible family members are paid in part by Eligible Employees with pre or post-tax dollars deposited into the general assets of the Employer and remaining premiums are paid by the Company out of its general assets.

The insurance companies, not Crouse Hospital are responsible for paying claims with respect to these programs. Crouse Hospital shares responsibility with the insurance companies for administering these program benefits.

[1] Long-Term Disability insurance coverage is no longer available in the Plan after August 1, 2019. If you were employed prior to August 1, 2019 your coverage will continue.

The following benefits under the Plan are self-funded with Employee pre-tax salary reduction contributions for the flexible spending account plan into the general assets of the Employer. The Employer submits contributions for the flexible spending account plan from the general assets to the program's administrator. The Employer pays claims for the self-funded medical, prescription drug, and dental coverage from its general assets.

Medical Coverage	Excellus Blue Cross Blue Shield
Prescription Drug Coverage	Excellus Blue Cross Blue Shield
Dental Coverage	Excellus Blue Cross Blue Shield
Flexible Spending Account Plan (including health care and dependent care spending accounts)	Lifetime Benefits Solutions

Purpose of the Plan Document

Crouse Hospital is providing this document to address certain information that may not be addressed in the attached group insurance contracts or third-party administrator booklets. This document, together with the group insurance contract issued by the insurance company, is the Plan document required by ERISA. This Plan document is not intended to give any substantive rights to benefits that are not already provided by the attached group insurance contracts.

The following is a list of Attachments to this document that have been previously made available to you. You may receive an additional copy with your written request to the Human Resources Department.

Attachment #	Benefit	Insurance Carrier or Third-Party Administrator / Group Numbers	Funding Status
1	Medical Coverage	Excellus Blue Cross Blue Shield Group Number: 113160 Select Blue PPO Super Blue PPO www.excellusbcbs.com	Self- Insured
2	Prescription Drugs	Excellus Blue Cross Blue Shield 1-800-499-1275 www.excellusbcbs.com	Self-Insured
3	Vision	Davis Vision Group Number: 500303 www.davisvision.com	Fully Insured
4	Dental Coverage	Excellus Blue Cross Blue Shield Group Number: 00123243 www.excellusbcbs.com	Self-Insured
5	Life and AD&D Insurance (including supplemental life insurance for Employees, Spouses and Dependents)	Symetra Group Number: 17932 www.symetra.com/ny	Fully Insured
6	Short Term Disability (NY-DBL)	CIGNA Group Number: NYD075703 www.cigna.com	Fully Insured
7	Short-Term Disability	CIGNA Group Number: NYK960387 www.cigna.com	Fully Insured
8	Long-Term Disability	CIGNA Group Number: NYK960388 www.cigna.com	Fully Insured
9	Voluntary Critical Illness	The Farmington Company www.farmingtonco.com	Fully Insured Individual Contracts

Attachment #	Benefit	Insurance Carrier or Third-Party Administrator / Group Numbers	Funding Status
10	Voluntary Benefit Program	The Farmington Company *See the Human Resources Department for more information regarding eligibility, benefits offered, premium payments, and enrollment.* www.farmingtonco.com	Fully Insured Individual Insurance Contracts
Exhibit A	Flexible Spending Account Program (including Health Care and Dependent Care Spending Accounts)	Lifetime Benefits Solutions www.lifetimebenefits.com	Self-Funded
11	Employee Premium Contribution Requirements – Rates - Open Enrollment Materials and New Hire Packets – this information can also be found on our benefits website – www.crouse.org/benefit/healthcare		

3. Eligibility and Participation Requirements

Eligibility for benefits includes coverage for Eligible Full-Time Employees, Spouses and Dependents.

Component Benefit	Eligibility
Medical, Prescription Drugs, Dental, Vision, Life and AD&D Insurance, Supplemental Life Insurance for Employees, Spouses and Dependents, Short-Term Disability (with voluntary buy-up coverage available), Voluntary Critical Illness, the Voluntary Benefit Program, and the Flexible Spending Account Program (including health care and dependent care spending accounts)	Eligible Employees scheduled to work 20 or more hours per week.[2]

You are not eligible to participate if you are employed by the Employer on a per diem, or contingent basis; if you are providing services to the Employer pursuant to an agreement with a third-party leasing organization; if you are an independent contractor who is not on an Employer payroll.

Employees must be enrolled in benefits prior to enrolling their eligible family members. To determine if you or your eligible family members are eligible to participate in a component benefit program, please read the eligibility information contained in the Attachments for the applicable component benefit programs or you may contact the Human Resources Department if you have any questions regarding your eligibility.

Component Benefit	When Participation Begins
Medical, Prescription Drugs, Vision, Dental, Life and AD&D Insurance, Supplemental Life Insurance for Employees, Spouses, and Dependents, Short-Term Disability (NY-DBL), Short Term Disability (with voluntary buy-up coverage available), Voluntary Critical Illness, the Voluntary Benefit Program, and the Flexible Spending Account Program (including health and dependent care spending accounts)	*Eligible Non-Union Employees:* 1st of the month following date of hire, rehire or change in employment classification from an ineligible to eligible status.

The Patient Protection and Affordable Care Act (Health Care Reform) requires employers who sponsor group health plans (including prescription drugs) to determine the eligibility of what is called a Variable Hour and/or Seasonal Employee. Eligibility determinations are made on the basis of hours worked within a certain timeframe. See the Human Resources Department for additional information regarding eligibility in the medical (including prescription drug) benefits program.

Health Care Reform – Termination and Subsequent Rehire
If you were a participant in the Plan at your date of termination of employment, if you are subsequently rehired, you will eligible to participate as if you were a newly hired Employee.

For purposes of the Affordable Care Act (Health Care Reform) and eligibility for medical (including prescription drugs) coverage, the Employer can treat a rehired Variable Hourly Employee as a new Employee if the Employee did not have an hour of service for at least 13 consecutive weeks before the Employee returns to work. The Employer may treat an Employee as rehired after a short period of at least four consecutive weeks during which no hours of service were credited if that period exceeds the number of weeks that the Employee originally worked for the Employer.

[2] See the Human Resources Department regarding eligibility for benefit programs based on your scheduled working hours per week. If you work less than 20 hours per week you may still be able to participate in benefit programs offered by paying a greater portion of the premium requirements.

Employees must enroll in the health insurance program within 30 days of their initial eligibility date. If you have experienced a mid-year change in family status or special enrollment under HIPAA as outlined below, you may enroll in the plan outside of the open enrollment cycle.

Medical, Prescription Drugs and Dental Benefit Opt-Out Program
Eligible Employees who wish to waive their right to coverage in the medical, prescription drugs and dental benefit program may be eligible for an opt-out credit provided you complete a Waiver and Certification Form to waive your rights to benefit programs offered. See the Human Resources Department for more information regarding eligibility for the waiver credit.

If you are an Eligible Employee, you may begin participating in the Plan on your election to participate in a component benefit program in accordance with the terms and conditions established for that program.

Leased or Temporary Employment
Leased employees or persons classified by Crouse Hospital as temporary employees of Crouse Hospital (as determined by the Employer) are not eligible for benefits under this Plan. A person who is not characterized by Crouse Hospital as an employee of Crouse Hospital but who is later characterized by a regulatory agency or court as being an employee will not be eligible for the period during which he or she is not characterized as an employee by Crouse Hospital.

Section 125 Eligibility
Crouse Hospital is a non-profit "C" corporation, if it should become a Sub Chapter S corporation, a sole proprietorship, a partnership, or a limited liability partnership; a sole proprietor, partner, limited liability company principal, limited liability partners and 2% shareholder of a sub chapter S corp. (as defined under applicable law) of Crouse Hospital and their Dependents may be covered under benefits offered in the Plan, they generally are not permitted to participate in the Code Section 125 pre-tax salary reduction feature of the Plan.

Special Enrollment Periods
Special Enrollment Rights – Health Insurance Portability and Accountability Act ("HIPAA"). If you, your Spouse or a Dependent is entitled to special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) under a group health plan, you may change your election to correspond with the special enrollment right. For example, if you declined enrollment in your Employer's Health Insurance Plan for yourself or your eligible Dependents because of medical coverage under another plan, and eligibility for such coverage is subsequently lost due to certain reasons (that is, due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage, provided that you request enrollment within **30 days** after the applicable event. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and a newly-acquired Dependent, provided that you request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption.

Special Enrollment Rights – Children's Health Insurance Program Reauthorization Act ("CHIPRA"). If you and your Dependents are eligible but not enrolled for coverage under your Employer's group health plan you may enroll you or your Dependent's if Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or 2) you may waive your rights to coverage for you or your Dependents if eligible for a Subsidy under Medicaid or CHIP (if offered by your state). You or your Dependent(s) must request coverage within **60 days** after you or your Dependent is terminated from or determined to be eligible for such assistance.

Change in Election Events – Section 125
If a Change in Election Event (including a Change in Status) occurs, you must inform the Human Resources Department and complete a new election form within 30 days of the occurrence. Your election will be effective as of the first of the month after the election form is completed and received by Human Resources. Special

enrollments in the event of birth, adoption, or placement for adoption will be effective back to the date of the birth, adoption, or placement for adoption, as long as timely notice is given to the Plan.

Prior to the beginning of each Plan Year, the Plan Administrator will provide information regarding enrollment or changes to your enrollment election. If you do not enroll or make changes to your enrollment, your elections will remain the same for the upcoming Plan Year, including an election of no coverage. The Employer reserves the right during any open enrollment period to ask you to re-enroll in any benefit program offered in the Plan.

To participate in the Health Care or Dependent Care Spending Accounts in the Flexible Spending Account Plan you must make an affirmative election during the Open Enrollment period. If you do not affirmatively enroll in the health care and/or dependent care flexible spending accounts, your participation in the flexible spending account plan will cease as of the end of the current Plan Year.

There are several important exceptions to the irrevocability rule, known as *Change in Election Events.* "Change in Election Events" include the following events, as more fully described below: FMLA leave, Change in Status, certain judgments, decrees and orders; Medicare and Medicaid: Change in Cost, and Change in Coverage. *(Change in Status, Cost and Coverage* are defined below). However, the Change in Election Events do not apply to all benefits in the Plan, exclusions apply. Examples are described below for each such Event.

1. **Family Medical Leave Act**. You may change your elections in the Plan upon commencement of or return from leave.
2. **Change in Status**. If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under subsequent IRS regulations:
   - A change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation or annulment). *"Spouse"* means the person who is legally married to you and is treated as a Spouse under the Internal Revenue Code *(Code)*;
   - A change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent). *"Dependent"* means your tax dependent under the Code;
   - Any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefit eligibility including (this Plan or other employee benefit plan of you, your Spouse, or your Dependents). Such events include any of the following changes in employment status, termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in work site, switching from salaried to hourly paid, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of Employment; or any other similar change which makes the individual become (or cease to be) eligible for benefits; and
   - An event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a benefit (such as attaining a specified age or similar circumstance).
3. **Change in Status-Other Requirements**. If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a change in Status event if the event affects coverage eligibility. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:
   - *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For health benefits (here, the medical insurance under the Health Insurance Plan), a special rule governs which type of election changes are consistent with the Change of Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the health benefits for the

affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.
Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee -plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year. Sharon loses eligibility for coverage under the Plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no health coverage. The health coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

- *Gain of Coverage Eligibility under another Employer's Plan.* For a Change in Status in which you, your Spouse or your Dependent gains eligibility for coverage under another employer's cafeteria plan (qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

4. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, legal separation, annulment or custody change requires your Dependent child (including a foster child who is your Dependent) to be covered under the Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, then you may change your election to revoke coverage for the child.
5. **Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's health coverage under the Health Insurance Plan. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, you may, subject to the terms of the underlying plan, elect to begin or increase that person's health coverage.
6. **Change in Cost.** If the Administrator notifies you that the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another Plan option that provides similar coverage or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if there is no option available under the Plan that provides similar coverage; (d) coverage under another employer plan, such as a Spouse's or Dependent's employer, is treated as similar coverage. For insignificant increases or decreases in the cost of benefits, however, the Administrator will automatically adjust your election contributions to reflect the minor change in cost.
7. **Change in Coverage.** You may also change your election for the Plan if one of the following events occurs:
   - *Significant Curtailment of Coverage.* If the Administrator notifies you that your coverage under the Plan is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible), then you may revoke your election and elect coverage under another Plan option that provides similar coverage. If the Administrator notifies you that your coverage under the Plan is significantly curtailed with a loss of benefit coverage, then you may either revoke your election and elect coverage under another Plan option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage but only if there is no option available under the plan that provides similar coverage.
   - *Addition or Significant Improvement of Plan Option.* If the Plan adds a new option or significantly improves an existing option, the Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the component Plan.
   - *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse or Dependent, if any of you loses coverage under any group health coverage

sponsored by a government or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).

- *Change in Election under another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan. For example, if an election is made by your Spouse during his/her employer's open enrollment to drop coverage, you may add coverage to replace the dropped coverage.

8. **Dependent Care Spending Account.** This event applies to Dependent Care Spending Accounts, but not to Medical Spending Accounts in the Flexible Spending Account Plan. You are permitted to change your election if a change in cost occurs during the Plan Year. If the caregiver is a relative, no change is permitted. As well, a significant coverage change or curtailment may apply to your Dependent Care Spending Account, but not to Medical Spending Accounts, when there is a change in provider, or eligibility for state-funded school resulting in decreased need for child care expenses. If there is a change in coverage of Spouses or Dependents under another Employer's Plan, you may be allowed to change your election in your Dependent Care Spending Account, but not the Medical Spending Account, under the Plan provided that the change is on account of and consistent with the change in coverage that is made under the other employer's plan and is also consistent with the rules under Section 125 of the Internal Revenue Code.

A change must be "on account of and correspond with" a Change in Status Event. To meet this requirement, the change that you wish to make must be on account of and correspond with a Change in Status Event that affects eligibility for coverage under the Plan. This rule is satisfied as to the Dependent Care Spending Account in the Flexible Spending Account Plan if the Change in Status Event affects expenses under that Account, such as when the child become 13 years old and is no longer a qualifying individual. The determination of whether a requested change is "on account of and consistent with" a Change in Status Event will be made by the Plan Administrator (in its sole discretion) in accordance with interpretations of the Internal Revenue Service.

If the employer adds a new benefit option or if an existing benefit option is significantly improved during a Plan Year or coverage period (as determined by the Plan Sponsor), you may change your elections to replace a benefit option that provides similar benefits with the new or improved benefit option, or, if you did not previously elect a similar benefit option, you may elect to begin participating in the new or improved benefit option.

Additionally, the Administrator may modify your election(s) in the medical (including prescription drugs), dental, vision, or flexible spending account benefits of the Plan downward during the Plan Year if you are a key employee or highly compensated individual (as defined by the Internal Revenue Code), if necessary, to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Election Mistakes

If the Plan Administrator determines, based on clear and convincing evidence, that an election was a mistake, the Plan Administrator may correct the mistake. The Plan is intended to qualify for tax favored treatment under Code Sections 125, 129 and 79. In some circumstances, a benefit otherwise payable to a highly compensated employee or key employee or other prohibited group identified in the Code may not be payable without violating the applicable Code Section. The Plan Administrator may treat the election associated with the benefit as a mistake and correct it.

Benefits for Adopted Children and Guardianship Agreements

With respect to component benefit plans that are group health plans, the Plan will extend benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of other participants.

Employee Participants who currently cover eligible dependents under a Guardianship Agreement will be required, upon enrollment and subsequent requests, to show proof of continued guardianship in order to continue coverage in the Plan for Dependent child(ren).

Termination of Participation

Medical (including prescription drugs), Vision, and Dental	The end of the month in which employment ends.
Life, AD&D, Supplemental Life (including Employees, Spouses and Dependents), Short Term Disability (NY-DBL), Short and Long-Term Disability, and Voluntary Critical Illness	The date employment ends
Flexible Spending Account Plan (including Health Care and Dependent Care Spending accounts)	Deposits stop with your final paycheck and reimbursement is made for eligible expenses incurred up to your date termination. Participants have 90 days following their date of termination to submit claims.

Please refer to the plan summaries or booklets for the applicable component benefit in the event of your termination of employment. To obtain information regarding your rights to conversion of your life and medical (including prescription drugs) insurance coverage to an individual policy, please contact the appropriate insurance carrier. Also see Section 5 – COBRA for continuation of your medical (including prescription drugs), vision, dental or flexible spending account (health care spending account) plan benefits.

Coverage may also terminate if:

- ✓ Your hours drop below any required hourly threshold;
- ✓ With respect to any coverage requiring Participant contributions and with respect to which Participant contributions are discontinued, the last day of the period for which contributions by the Participant are paid;
- ✓ You submit false claims; or
- ✓ If Crouse Hospital discontinues the plan for any reason.

Coverage will end at:

- ✓ The end of the month following the day on which an eligible dependent cease to be an eligible dependent in the medical, prescription drugs, vision and dental benefits;
- ✓ Except in the case of certain leaves of absence, the day on which the participant ceases to qualify as an active eligible employee of Crouse Hospital unless otherwise specified (see the Termination of Participation provisions above); or
- ✓ Except to the extent required by law, the first day of the month following the date on which the participant reports for active duty as a member of the armed forces of any country, in the case of the Plan's medical, prescription drugs, vision and dental coverage the day on which the participant reports for such active duty, with respect to the Plan's life and AD&D, short and long term disability insurance.

Uniformed Services Employment and Re-employment Rights Act ("USERRA")

Regardless of any provision described above, if you take a leave of absence from employment with Crouse Hospital because of military service, you may elect to continue coverage under the Plan to the extent required by USERRA for you and your covered Spouse or Dependents or you may extend benefits through COBRA.

You have the following rights under USERRA:

1. If your military leave period is for 30 days or less, you have the right to continue health coverage for yourself and dependents that were covered under the group health plan for up to 30 days, at a cost of not more than the cost for a similarly situated active employee.

2. If the military leave period is for 31 days or more, you have the right to elect USERRA continuation coverage for yourself and your dependents that were covered under the health plan. The maximum period is 24 months.

You will be required to pay up to the 102% of the applicable premium whether you elect continuation coverage under USERRA or COBRA.

If you extend your coverage through USERRA, such coverage will end on the earlier of: (1) the last day of the 24-month period beginning on the date your absence begins; or (2) the day after the date on which you fail to apply for or return to a position of employment with Crouse Hospital. See the COBRA section of this document for more information on continuation of coverage through COBRA.

If you elect USERRA continuation coverage, the Plan is under no further obligation to offer COBRA election rights when the USERRA continuation coverage expires. However, if your Spouse or Dependent child would lose USERRA continuation coverage because of another qualifying event, such as your death or divorce, or because the Dependent ceases to be an eligible Dependent, then the Plan must offer your Spouse or Dependent child the right to continue coverage for 36 months measured from the date you entered active military service.

If you take military leave, but your coverage under the Plan is terminated – for instance, because you do not elect the extended coverage, when you return to work, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies. Please contact the Plan Administrator if you have questions about coverage during periods of military service.

Termination of Coverage for Cause, Including Fraud or Intentional Misrepresentation

The Employer reserves the right to terminate coverage for you, your Spouse, or your Dependent(s) prospectively without notice for cause or if you, your Spouse, or your Dependent(s) are otherwise determined to be ineligible for coverage under the Plan. In addition, if you, your Spouse, or your Dependent(s) commits fraud or intentional misrepresentation in an application for coverage under the Plan, in a claim or appeal for benefits, or in response to any request for information by the Plan Administrator, a claims administrator, an appeals administrator, or the Employer, the Plan Administrator may terminate your, your Spouse's, or your Dependent's coverage retroactively to the date of the fraud or misrepresentation upon 30 day notice.

When you enroll a family member in the Plan, you represent the following:

- The individual is eligible under the terms of the plan; and
- You will provide evidence of eligibility on request.

Further, you understand that:

- The Plan is relying on your representation of eligibility in accepting the enrollment of your family members;
- Your failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation; and
- Your failure to provide evidence of eligibility will result in disenrollment of the individual, which may be retroactive to the date as of which the individual becomes ineligible for Plan coverage, as determined by the Plan Administrator and subject to the Plan's provisions on rescission of coverage.

If the medical (including prescription drugs), vision or dental program undertakes an eligibility audit and finds an ineligible Spouse or Dependent(s) enrolled in the Plan, the Plan may cancel coverage for the ineligible Spouse or Dependent(s) prospectively without violating the prohibition on rescission rules of the Affordable Care Act. A termination of coverage with prospective effect is not considered a rescission and may be permitted without proof of fraud or misrepresentation.

In order to cancel coverage retroactively, however, the Plan must make a showing of fraud or intentional misrepresentation of a material fact and provide advance written notice of the rescission.

4. HIPAA Rights for Health Care Benefits

This provision shall only apply to benefits that are subject to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and its implementing regulations, issued under the Privacy Regulations at 45 C.F.R. Parts 160 and 164.

This section shall be interpreted in a manner that permits the Plan to comply with HIPAA and other federal and state laws regarding protection of Protected Health Information ("PHI").

The health component benefits of the Plan will use and disclose PHI, as defined in 45 CFR 164.501, to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the health component benefits will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations as defined in the health component benefit HIPAA Privacy Notice (as defined in 45 CFR 164.520) distributed to Participants.

Health i*nformation* means any information, whether oral or recorded in any form or medium, that:

a) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
b) Relates to the past, present, future physical or mental health or condition of any individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual; and:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future payment for the provision of health care to an individual; and
    a. Identifies the individual; or
    b. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

PHI means individually identifiable health information (defined above):

1. Except as provided in paragraph (2) of this definition; that is:
    a. Transmitted by electronic media;
    b. Maintained in electronic media; or
    c. Transmitted or maintained in any other form or medium.
2. PHI excludes individually identifiable health information in:
    a. Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g:
    b. Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and
    c. Employment records held by a covered entity in its role as employer.

The HIPAA Privacy Rules covers PHI in any medium while the HIPAA Security Rule covers electronic protected health information ("e-PHI").

The health component benefits of the Plan will disclose PHI to Crouse Hospital only upon receipt of a certification from Crouse Hospital that this Summary Plan Description has been amended to incorporate the provisions below and that the Employer agrees to certain conditions regarding the use and disclosure of PHI and the adequate separation between the health component benefits and Crouse Hospital.

Crouse Hospital's Obligations with Respect to PHI

With respect to PHI, Crouse Hospital agrees to certain conditions. Crouse Hospital agrees to:

- not use or disclose PHI other than as permitted or required by this Summary Plan Description or as required by law;

- ensure that any agents (including a subcontractor) to whom Crouse Hospital provides PHI received from the Plan agree to the same restrictions and conditions that apply to Crouse Hospital with respect to such PHI;
- not to use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of Crouse Hospital unless authorized by an individual;
- report to the Plan any PHI use or disclosures of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Health and Human Services Secretary for the purposes of determining the Plan's compliance with HIPAA;
- if feasible, return or destroy all PHI received from the 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 (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- Crouse Hospital will follow the privacy and security obligations required under the Health Information Technology for Economic and Clinical Health Act ("HITECH"), including notification of a breach involving unsecured PHI within the required 60-day timeframe, securing PHI, and development of procedures for breach identification.

Access to PHI within Employer

Protected health information may be disclosed to the Plan Sponsor to perform the administrative functions listed below only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions and the plan sponsor has agreed to:

(A) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
(B) Ensure that any agents to whom it provides protected health information received from the group health plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
(C) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
(D) Report to the group health plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
(E) Make available protected health information in accordance with § 164.524;
(F) Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with § 164.526;
(G) Make available the information required to provide an accounting of disclosures in accordance with § 164.528;
(H) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the group health plan available to the Secretary for purposes of determining compliance by the group health plan with this subpart;
(I) If feasible, return or destroy all protected health information received from the group health plan that the sponsor still maintains in any form and retain no copies of such information 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 the information infeasible; and
(J) Ensure that there is adequate separation between the group health plan and the Plan Sponsor.

Adequate separation will be maintained between the group health plan and the Plan Sponsor.

Employees who work in the Plan Sponsor's Benefits or Human Resources Department will have access to PHI:

(A) To the extent necessary to assist Plan participants and their family members with getting benefit claims resolved;

(B) That is the result of pre-employment physicals requested or required by the Plan Sponsor before hiring prospective employees;

(C) To the extent necessary to fulfill any responsibility they may have to review and determine claims and appeals of denied claims under this Plan;

(D) To the extent necessary to monitor and enforce the subrogation provisions of the Plan, and work with the Plan Sponsor's subrogation entity to help the Plan obtain reimbursement when appropriate;

(E) For activities related to ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care; and

(F) To the extent necessary to correspond with other group health plans on coordination of benefits issues. Employees who work in the Plan Sponsor's Legal Department will have access to PHI to the extent necessary to: (i) enforce the provisions of the Plan; and (ii) respond to, defend against, and provide necessary information to outside counsel for responding to or defending against, lawsuits against the Plan, Plan Sponsor or Plan fiduciaries, or other lawsuits that require benefits information or PHI.

Employees who work in the Plan Sponsor's Finance Department will have access to PHI to the extent necessary to conduct an internal audit of the Plan's expenses and payments of claims.

Designated employees who work in the Plan Sponsor's Care Coordination Department will have access to minimally necessary PHI:

(G) To the extent necessary to perform navigation services, utilization review and case management services specific to facility admissions;

Designated employees of the Crouse Health Network practices will have access to minimally necessary PHI:

(H) To the extent necessary to perform ongoing care management services.

If the persons described herein or any other employees do not comply with these provisions, the group health plan shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. The Plan Sponsor shall cooperate with the Plan to correct and mitigate any such noncompliance.

Privacy Official

The Privacy Official shall be responsible for compliance with Crouse Hospital and the health component benefits obligations under this section and HIPAA. The Privacy Official for Crouse Hospital is the Director of Human Resources, John Bergemann. Specific rules regarding the Privacy Official follow:

1. Appointment, Resignation and Removal of Privacy Official. Crouse Hospital shall appoint one or more individuals to act as Privacy Official on matters regarding the health component benefits. The individual appointed as Privacy Official may resign by giving 30-day notice in writing to Crouse Hospital. Crouse Hospital shall have the power to remove that individual for any or no reason.
2. Policies and Procedures. The Privacy Official shall from time to time formulate and issue to Participants and Crouse Hospital such policies and procedures as he or she deems necessary for substantive provision of the health component benefits. Additionally, such policies and procedures must be accepted by the Plan Administrator.
3. Privacy Notice. The Privacy Official shall be responsible for arranging with Crouse Hospital, the Plan Administrator and any third-party administrator for the issuance of, and any changes to the Privacy Notice under the health component benefits.
4. Complaint Contact Person. The Privacy Official shall be the contact person to receive any complaints of possible violations of the provisions of this section and HIPAA. The Privacy Official shall document any complaints received, and their disposition, if any. The Privacy Official shall also be the contact to provide further information about matters contained in the health component benefits HIPAA Privacy Notice.

If you believe your privacy rights have been violated, you may file a complaint with the Director of Human Resources of Crouse Hospital or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.
You will not be penalized or retaliated against for filing a complaint.

HIPAA Security Standards
This section explains Crouse Hospital's obligations with respect to the security of e-PHI under the security standards of HIPAA.

Where e-PHI will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, Crouse Hospital will reasonably safeguard the e-PHI as follows:

- Crouse Hospital will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI that Crouse Hospital creates, receives, maintains, or transmits on behalf of the Plan,
- Crouse Hospital will ensure that the adequate separation that is required by the HIPAA Privacy Rule is supported by reasonable and appropriate security measures,
- Crouse Hospital will ensure that any agent, including a subcontractor, to whom it provides e-PHI agrees to implement reasonable and appropriate security measures to protect such e-PHI, and The Plan Sponsor will report to the Plan any security incidents of which it becomes aware as described below:
  - ✓ Crouse Hospital will report to the Plan within a reasonable time after the Plan Sponsor becomes aware, any security incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's e-PHI, and
  - ✓ Crouse Hospital will report to the Plan any other security incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

5. COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

There may be other coverage options for you and your family. You will be able to buy coverage through the Health Insurance Marketplace during the open enrollment period or if you have a special enrollment opportunity. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

If you or your eligible family members qualify for continuation coverage, the medical, prescription drugs, vision, dental, or flexible spending account (health care spending account) programs will be treated as individual plans for purposes of COBRA.

New York state law requires insurers to offer employees and their dependents to continue coverage for those who are not covered by an employer or government plan (such as Medicare) for a period of up to 36 months.

New York state law provides an option to continue coverage for unmarried children who have "aged out" of their parent's group health policy. Such children are not required to be financially dependent on their parents to elect this benefit. Continuation coverage may continue through age 29 as long as they are not entitled to Medicare or covered under another group health insurance.

Always check with your COBRA Administrator listed at the end of this section regarding your rights under Federal and State COBRA laws.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of the medical, prescription drugs, vision, dental, or flexible spending account coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, Spouse, or Dependent, you will become a qualified beneficiary if an Employee loses coverage. An eligible Employee, covered Spouse or covered Dependent is entitled to 18 months of coverage under the Plan because either one of the following qualifying events happen:

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

If you are the Spouse of an employee, you will become a qualified beneficiary if you lose your coverage. You are entitled to 36 months of coverage under the Plan because any of the following qualifying events happen:

- Your Spouse dies;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage. They are entitled to 36 months of coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The parent-employee can no longer claim you as a "dependent child" under the Plan.

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan's COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the COBRA Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and Spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify Crouse Hospital in writing within 60 days after the later of when the qualifying event occurs or the date that you would lose benefits due to a qualifying event. The Employee or family member can provide notice on behalf of themselves, as well as other family members affected by the qualifying event. Written notice of the qualifying event should be sent to Crouse Hospital and should include the following information:

Date (month/day/year)
Social Security Number / ID Number
Spouse / Dependents Telephone Number
Date of Birth (month/day/year)
Employer's Name
Employee's Social Security Number / ID Number
Loss of Coverage (month/day/year)
Spouse / Dependent's Name
Spouse / Dependent's Address
Gender
Relationship to Employee
Employee's Name
Reason for Loss of Coverage

How is COBRA Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becomes entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child losing eligibility as a Dependent child, COBRA continuation

coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

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

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

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

Paying for Continuation Coverage

You do not have to show that you are insurable to choose COBRA continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage. Your employer reserves the right to charge an additional 2% administration fee in addition to the regular premium.

For disability extensions up to 29 months if an individual is determined to be disabled (for Social Security disability purposes) Crouse Hospital reserves the right to charge an additional 50% of the regular premium. There is a grace period of at least 30 days for payment of the regularly scheduled premium. The law also says, that at the end of the 29 month or 3-year continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under your insurance carrier.

Most coverage under COBRA is paid for with the value of your premiums (plus a 2% administration fee) associated with each insured benefit (i.e. medical (including prescription drugs), vision and dental). If you have not incurred claims sufficient to spend-down your account balance as of your date of termination, you may continue your participation in the Flexible Spending Account Plan Health Care Spending Account for the remainder of the current Plan Year. Payment for continuation of your Flexible Spending Account Plan Health Care Spending Account benefit is based on the contribution you made to your account while employed. Your premium is the same amount of those contributions withheld from your paycheck during employment. ***COBRA will be offered only to those who have "underspent" their Health Care Spending Account.***

Grace period for monthly payments

lthough monthly payments are due on the first day of each month of COBRA coverage, COBRA participants will be given a grace period of 30 days to make each monthly payment. COBRA coverage will be provided for each

month as long as payment is made before the end of the grace period for that payment, but coverage is subject to being suspended as explained below.

If payment is made after the due date but before the end of the 30-day grace period for that month, health coverage may be suspended as of the first day of the month when payment was due. Coverage will be retroactively reinstated (going back to the first day of the month) when the payment for that month is received. Any claim(s) submitted for reimbursement while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

Termination of Continuation Coverage
The law also provides that your continuation coverage may be terminated for any of the following reasons:

1. Crouse Hospital no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become entitled to Medicare;
4. A qualified beneficiary becomes covered under another group health plan.

The Trade Preferences Extension Act of 2015 and COBRA
The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals typically include those who have been displaced due to foreign competition). The Trade Preferences Extension Act restored the provisions of the Trade Act of 2002 which expired on January 1, 2014. Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of a portion of premiums paid for qualified health insurance including continuation coverage. The new legislation also added rules for coordinating the health care tax credit with the premium tax credit that is available under health care reform to eligible individuals receiving individual health insurance through an Exchange. A new rule excludes coverage through an Exchange from the list of qualified health insurance for which the health care tax credit may be claimed beginning in 2016. There is also a new requirement to make an election in order for the health care tax credit to apply, and the premium tax credit is not available for the months to which the election applies.

If You Have Questions
Questions concerning your participation in the Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

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

Plan Contact Information for return of COBRA Election Forms and Premium Payments:
COBRA Election Forms and premium payments should be mailed to:

Lifetime Benefits Solutions
333 Butternut Drive
Syracuse, NY 13214

Customer Service: 1-800-356-1029
Fax: 877-256-7228
lbscustomerservice@lifetimebenefitssolutions.com

ANY NOTICE THAT YOU PROVIDE MUST BE IN WRITING. ORAL NOTICE, INCLUDING NOTICE BY TELEPHONE, IS NOT ACCEPTABLE. YOU MUST MAIL, FAX OR HAND-DELIVER YOUR NOTICE TO THE PERSON, DEPARTMENT OR FIRM LISTED ABOVE.

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

- The name of the Plan or Plans under which you lost or are losing coverage;
- The name and address of the Employee covered under the Plan;
- The name(s) and address(es) of the Qualified Beneficiary(ies); and
- The Qualifying Event and the date it happened.

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

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

6. Qualified Medical Child Support Order

With respect to component benefit plans that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order, or "QMCSO" (defined in ERISA Section 609(a)). The Plan will provide benefits to Dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of Dependent children who are natural children of participants or beneficiaries, in accordance with ERISA Section 609(c).

In order for this Plan to recognize a QMCSO it must satisfy the following criteria:

It must be a judgment, decree or other court order relating to health benefits coverage for a Dependent child of a covered Employee, and the order must specify:

a. the name and address of the Employee or their designee;
b. the order must indicate who will pay for the Alternate Payee's coverage (required contributions towards premium, deductibles, coinsurance, copayments or other benefit payments);
c. statement that acknowledges the Plan's right to terminate coverage under the Order for which payment is not made on a timely basis as required;
d. the name and mailing address of each dependent child covered by the order;
e. a reasonable description of the type of coverage offered by the Plan;
f. a beginning period for which the order applies;
g. an end date for which the Alternate Payee would no longer be eligible for coverage;
h. social security number of each Dependent child covered by the order; and
i. the name and address of each Alternate Payee, which means the Spouse, former Spouse, legal guardian of the Dependent child or the child of an Employee.

Upon receipt of a medical child support order, the Plan Administrator shall promptly notify the Employee and Alternate Payee. The Plan Administrator shall determine whether an order received meets the criteria and promptly notify the Employee and each Alternate Payee. In the event of a dispute regarding any medical child support order furnished to the Plan Administrator, the Employee or Alternate Payee shall promptly notify the Plan Administrator in writing.

Coverage shall commence upon either the date specified in the order or the date the Employee becomes eligible for coverage, if later.

Any order that requires the Plan to provide any type of benefit or increased benefits not otherwise provided by this Plan, other than under COBRA, will not be recognized as a QMCSO.

Please see the Plan Administrator for questions regarding QMCSOs.

7. How the Plan is Administered

The administration of the Plan is under the supervision of the Plan Administrator, Crouse Hospital and the duly authorized person(s) who acts on behalf of the Plan Administrator. The named fiduciaries with respect to the management and control of the Plan's administration and operation shall be the Plan Administrator.

Any duly authorized officer of the Plan Administrator may exercise any authority or responsibility allocated or reserved to the Plan Administrator under this Plan. The Plan Administrator shall have the right to hire all persons providing services to the Plan and to appoint a claim fiduciary to receive, review, and to process claims for benefits.

Right to Receive and Release Necessary Information
Each of (i) Crouse Hospital or (ii) contract administrator (with respect to participants or beneficiaries receiving benefits under the Plan which it administers or provides services with respect to) may, without the consent of or notice to any person, release or obtain any information which such Plan Sponsor or contract administrator reasonably deems necessary in order to perform its duties under the Plan. Any person claiming benefits under the Plan shall furnish such information as may be reasonably required by Crouse Hospital or contract administrator. Crouse Hospital or any contract administrator will act in accordance with the rules established under the Health Insurance Portability and Accountability Act's Privacy and Security Rules.

Discretion of the Plan Administrator
In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's determinations shall be given deference and shall be final and binding on all interested parties.

Duties of the Plan Administrator

1) To administer the Plan in accordance with its terms for the exclusive benefit of persons entitled to participate in the Plan;
2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions;
3) Prescribe applicable procedure, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan;
4) To decide disputes that may arise relative to a Plan participant's rights;
5) To prescribe procedures for filing a claim for benefits and to review claim denials;
6) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;
7) To reject elections or to limit contributions or benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Internal Revenue Code;
8) To provide Employees with reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;
9) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609;
10) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Plan Administrator determines shall be paid if the Plan Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Plan Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;
11) To appoint a Claims Supervisor to pay self-insured claims, or to appoint agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan; and
12) The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

Plan Administrator Compensation
The Plan Administrator serves without compensation however, all expenses for plan administration, including compensation for hired services, will be paid by Crouse Hospital.

Crouse Hospital will bear its incidental costs of administering the Plan.

Power and Authority of Insurance Company
Certain benefits under the Plan are fully insured and provided by contract with an insurance company. Crouse Hospital has insurance contracts to provide for the following benefits:

Davis Vision	Vision
Symetra	Life and AD&D, Supplemental Life Insurance for Employees, Spouses, and Dependents
CIGNA	Short and Long-Term Disability
CIGNA	Short-Term Disability (NY-DBL)
UNUM	Voluntary Critical Illness

The insurance companies are responsible for (1) determining eligibility for and the amount of any benefits payable under their respective component benefit plans, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective component benefit plans.

Power and Authority of Insurance Company or Third-Party Administrator
The Plan also has benefits that are self-insured with administrative services provided by a third-party administrator or insurance company. The Plan Administrator has delegated certain responsibilities to the third-party administrator or insurance company and they are responsible for (1) determining eligibility for and the amount of any benefits payable under their respective component benefit plans, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective component benefit plans.

The Company has contracts with the following third-party administrator to provide benefits and process claims in the following program:

Medical and Dental Coverage	Excellus Blue Cross Blue Shield
Prescription Drugs	Excellus Blue Cross Blue Shield
Flexible Spending Account Plan	Lifetime Benefits Solutions

Questions
If you have questions regarding eligibility for, or the amount of, any benefit payable under the fully insured component benefit plans, please contact the appropriate insurance company, third party administrator, or the Plan Administrator.

8. Family and Medical Leave

Benefit and Service Continuation during Family and Medical Leave ("FMLA")

During the period of your leave under this Plan, the Plan will continue your medical (including prescription drugs) coverage, as required by law. This means Crouse Hospital will continue your benefits on the same basis as if you were continuing your employment.

Employees on unpaid leave are required to pay premiums if you are participating in the medical, dental, flexible spending account plan or supplemental life insurance during your leave. You will be invoiced each month for premiums due and they can be paid during your leave with post-tax dollars. The method of payment will be chosen at the discretion of the Plan Administrator.

If you elect to cease participation in any benefit in which you participate, expenses incurred while participation has lapsed will not be eligible for reimbursement. If you elect to continue participation in the dependent care spending account, expenses incurred during the leave would not be eligible for reimbursement because you are not working, but contributions could be made during the leave and applied to expenses incurred after you return from leave.

If you elect to cease participation during the leave period, coverage will resume upon your return to work under your prior elections, unless changed by you in accordance with the Change in Election Event rules described above. However, you have two choices regarding the flexible spending health care spending account:

- You can elect to have your contributions resume at the level in effect prior to the leave, in which case the annual medical account contribution you elected would be reduced to reflect the period of no contributions.
- You can elect to increase your contributions for the remainder of the year following the leave so that your annual contribution to the flexible spending medical account will equal the annual contribution in effect prior to the leave.

For example, suppose you had elected a $1,200 flexible spending medical account (monthly contributions of $100) and were absent on leave for the months of April, May and June. When you return to work in July, you could continue to make contributions of $100 per month, in which case the maximum annual reimbursement from the flexible spending medical account would be $900 ($1,200 minus $300 in missed contributions). Alternatively, you could increase your monthly contribution to $150 for the remainder of the year and have a maximum annual reimbursement from the flexible spending medical account of $1,200 (three months of $100 contributions, three months of $0 contributions and six months of $150 contributions).

If you elect to cease participation during the leave period, coverage will resume upon your return to work under your prior elections, unless changed by you in accordance with the Change in Election Event rules described above.

- ❖ Leaves of absence under this policy shall *not* constitute a break in the employee's length of continuous service nor will you lose any employment benefits you have accrued prior to taking leave.

- ❖ If you terminate your employment during your leave, the date of your qualifying event will be the day of your termination of employment.

If you have questions regarding procedures and guidelines for the FMLA you may also contact the Plan Administrator.

9. Amendment or Termination of the Plan

The Plan Administrator shall have the unlimited right to amend, terminate, or merge the Plan at any time without prior written notice to any Participant. Any such amendment, termination, or merger shall be documented in writing by an authorized representative of the Employer and shall become effective as of the date specified in the appropriate documentation. Any such amendment, termination or merger shall be binding upon all Employees and Dependents (including those Participants on continuation coverage). However, the responsibilities of the named fiduciaries and their delegates shall not be increased or changed without their written consent.

No change in this Plan will be valid unless it is approved by the Plan Administrator or the duly authorized representative of the Plan Administrator. No one has the authority to make any oral modification to the Plan. Any change must be endorsed by the Plan Administrator or the duly authorized representative of the Plan Administrator and attached to this Plan Document. An amendment to this Plan may be retroactively effective but shall not adversely affect the rights of a Participant under this Plan for benefits provided after the effective date of the amendment but before the amendment is adopted.

In the event of termination of the Plan or any benefit program in the Plan, claims or expenses incurred prior to the termination shall be paid in accordance with the terms of the relevant benefit program.

Additionally, the Company reserves the right to determine from time to time the level of contribution required from Participants for Plan coverage.

Any provision of the Plan which, on its effective date, is in conflict with the requirement of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

10. No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and Crouse Hospital to the effect that you will be employed for any specific period of time.

11. Claim Procedures – Fully Insured Benefit Programs

This Summary Plan Description is intended to provide summary information regarding claims procedures. Always review the attached insurance carrier booklets, summary plan descriptions or governing documents for more information about how to file a claim and for details regarding the insurance company's claim procedures.

For purposes of the determination of the amount of, and entitlement to, benefits of the component benefit programs provided under insurance contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form. In that case, the form is available from the Plan Administrator.

The insurance company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurance company denies your claim, in whole or part, you will receive a written notification explaining the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide your appeal in accordance with its reasonable claims procedures, as required

by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court). You have voluntary rights to an external appeal if your internal appeal is denied.

CLAIMS AND APPEALS TIMETABLE

	Type of Claim	Timing for Claim Decision	Timing and Notification of Appeal Decision(s)
Medical Prescription Drugs Dental Vision Flexible Spending Health Care Spending Account	Urgent Care Claims	As soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of your claim by the Claims Administrator. Note that this notice may be given to you orally within the applicable time period, and a written or electronic notice will follow within three days of such oral notice.	As soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of your request for review by the Claims Administrator.
	Pre-Service Claims	Within a reasonable period of time appropriate to the medical circumstances but not later than **15 days** after receipt of your claim by the Claims Administrator, unless an extension of up to an additional **15 days** is necessary due to matters beyond the control of the Claims Administrator.	A reasonable period of time appropriate to the medical circumstances, but not later than **30 days** after receipt of your request for review by the Claims Administrator.
	Post-Service Claims	Within a reasonable period of time, but not later than **30 days** after receipt of your claim by the Claims Administrator, unless an extension of up to an additional **15 days** is necessary due to matters beyond the control of the Claims Administrator.	A reasonable period of time, but not later than **60 days** after receipt of the request for review by the Claims Administrator.
	Concurrent Care Claims	An extension of a course of treatment will follow the pre-service, post-service or urgent care procedures above, but a claim for urgent care continuation submitted **24 hours** before the end of the approved course of treatment must be processed within **24 hours** instead of **72 hours**.	An appeal for an extension of a course of treatment will follow the pre-service, post-service or urgent care procedures above
Short and Long-Term Disability		Within a reasonable period of time, but not later than **45 days** after receipt of your claim by the Claims Administrator, unless an extension of up to an additional **30 days** is necessary due to matters beyond the control of the Claims Plan Administrator.	A reasonable period of time, but not later than **45 days** after receipt of your request for review by the Claims Administrator. May be extended for an additional **45 days**.*
All Eligibility Determinations and Other Benefits	Includes Life, AD&D, Dependent Care Spending Accounts	Within a reasonable period of time, but not later than **90 days** after receipt of your claim by the Claims Administrator.	A reasonable period of time, but not later than **60 days** after receipt of the request for review by the Claims Administrator. May be extended for an additional **60 days**.*

* Upon written notice explaining the special circumstances that create a need for an extension.

Notice of Decision of Claim – Health, Dental or Vision Plan

If your claim for benefits under the Plan is denied, you will receive a written notice of the decision to deny the claim within 30 days after Excellus Blue Cross Blue Shield or Davis Vision (the designated claims processor) receives the claim, unless special circumstances require an extension of up to 15 additional days to process the claim. If such an extension of time for processing the claim is required, as determined in the designated claims processor's sole discretion, you will receive written notice of the extension before the end of the initial 30-day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the designated claims processor expects to render a benefit determination. If your claim for benefits under the Plan is denied, the written notice of denial shall include:

- The specific reason or reasons for the denial;
- Reference to pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit the claim for review.

Review Procedures for Denied Claims under the Health, Dental and Vision Plans
The following claims review procedures apply without regard to any conflicting procedures described in the attached booklet.

Appeal. If your claim for benefits is denied, you may file a written request for review in accordance with the procedures described in this paragraph. Additionally, if you receive no notification as to the disposition of your claim or no notification as to an extension of the determination period within 90 days after submission of the claim to the designated claims processor, the claim for benefits will be deemed to have been denied. If your claim has been denied or is deemed to have been denied, you may appeal the denial of the claim by filing a written request for review with the Claims Administrator.

You must file a written request for review of a denied claim within 60 days after you receive written notice of the denial of the claim, or within 60 days after the date such claim is deemed to be denied. In connection with an appeal, you shall be permitted to review pertinent documents with respect to your claim, as determined by the Claims Administrator. Additionally, you may submit to the Claims Administrator written issues and comments relating to your claim in connection with the Claims Administrator's review of your claim.

Review: The Claims Administrator will review claims submitted for its review in writing and within the periods described in the previous paragraph. The Claims Administrator will render a decision regarding the claim within 60 days after the date the Claims Administrator receives your request for review, unless the Claims Administrator, in its sole discretion, determines that special circumstances require an extension of time for reviewing the claim, in which case the Claims Administrator will render a decision as soon as possible, but not later than 120 days after the Claims Administrator's receipt of your request for review. If such an extension of time for review is required, the Claims Administrator shall furnish written notice of the extension of time to the claimant before the end of the initial 60-day period. The extension notice shall indicate the special circumstances requiring an extension of time.

The Claims Administrator may, in its sole discretion, request additional information or a meeting to clarify any matters related to the review of the claim.

Disposition on Review: You will receive written notification of the Claims Administrator's decision as to the disposition of a claim submitted for review and the notice will be written in a manner calculated to be understood by you. If your claim is denied on review, the notice shall include:

- The specific reason or reasons for the denial of the claim; and
- Specific references to pertinent plan provisions on which the benefit determination is based.

If the decision on review is not furnished within the period specified above, the claim shall be deemed denied on review at the expiration of that period.

If you have questions about claims procedures, contact:

Customer Services toll-free number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

Rights to an External Appeal – Medical (including prescription drug) Benefits
Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if insurance company has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative, with your acknowledgment and consent, may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

You will lose your right to an external appeal if you do not file an application for an external appeal within a period of time stated in the attached insurance contract.

The external appeal program is a voluntary program. Please refer to the appropriate attachment to this document for more information on requesting an external appeal.

You may, upon request and free of charge, obtain the identity of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination regarding your claim, without regard to whether such expert's advice was relied upon in making a benefit determination on review.

The insurance company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide on your claim. If the insurance company denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for denial.

See the certificate of insurance for more information about how to file a claim and for details regarding the claims procedures of the applicable insurance company.

Claim Procedures for Self-Funded Plans – Medical, Prescription Drugs, Dental and Flexible Spending Account Program
For purposes of determining the amount of, and entitlement to benefits under the component benefit programs provided through employee contributions, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

The Plan Administrator will delegate the responsibility to a Third-Party Administrator to decide your claim in accordance with reasonable claims procedures, as required by ERISA. If the Plan Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for denial.

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide you appeal in accordance with reasonable claims procedures, as required by ERISA. If you don't appeal in accordance with ERISA appeals in the claims procedures section of this document, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

Please refer to the Attachments to this document and Exhibit A for the Flexible Spending Account Program to determine specific claim procedures as provided by the Claims Administrators for self-funded benefit programs.

Denied Claims Made Under the Short or Long-Term Disability Plan
If your claim for benefits under the STD or LTD Plan is denied, you will receive a written notice of the decision to deny the claim within 45 days after the receipt of the claim by ***CIGNA*** or any successor thereto ("Disability Claims Processor"), unless the Disability Claims Processor determines that matters beyond the control of the Plan necessitate an extension of up to 30 days to process the claim. If the Disability Claims Processor determines that a decision cannot be rendered during the first 30-day extension period due to matters beyond the control of the Plan, the period for making a determination regarding your claim may be extended for an additional 30 days.

If an extension of time for processing the claim is required (as described above), you will be provided with an explanation of the circumstances requiring the extension of time, including the following information:

- The date by which the Disability Claims Processor expects to render a decision on the claim;
- An explanation of the standards on which entitlement to a benefit is based;
- A description of the unresolved issues that prevent a decision on the claim; and
- A description of additional information needed to resolve such issues.

If the extension notice requires you to provide additional information to process your claim, you must provide the information to the Disability Claims Processor within 45 days after the date the notice is sent to you. If an extension notice requests specific information, the extension period will not begin to run until you respond to the Disability Claims Processor's request for information. If you do not respond to the Disability Claims Processor's request for additional information within 45 days, your claim will be decided without such information.

If your claim for benefits under the STD or LTD Plan is denied, the written notice of denial shall be provided in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant and will include the following information:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material and information is necessary;
- A discussion of the decision, including reasons for disagreeing with views of treating professionals, medical or vocational experts consulted, or Social Security disability determination;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;
- The specific internal rules, guidelines, protocols, or other similar criterion relied on in making the adverse determination, a statement that a copy of such rule, guideline, protocol, or other criterion was relied upon in making the adverse determination and will be provided to the claimant free of charge upon request or a statement that such internal guidelines or criteria do not exist; and
- If the denial is based on a medical necessity or experimental treatment or other similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided to the claimant free of charge upon request.

Review of Claims Made under the Short or Long-Term Disability Plan

The following claims review procedures apply to the review of claims denied under the STD or LTD Plan without regard to any conflicting claims appeal or review procedures described in the attached booklet.

Appeal: If your claim for benefits under the STD or LTD Plan is denied, you may file a written request for review in accordance with the procedures described in this paragraph. Additionally, if you receive no notification as to the disposition of your claim under the STD or LTD Plan or no notification as to an extension of the determination period within 45 days after submission of the claim to the Disability Claims Processor, the claim will be deemed to have been denied. If your claim has been denied or is deemed to have been denied, you may appeal the denial of the claim by filing with the Claims Administrator a written request for review, provided that your request for review of a claim must be submitted within 180 days after (a) your receipt of the written notice of the denial or (b) the date of the deemed denial of the claim.

Review: The Claims Administrator will review claims submitted for its review in writing and within the periods described in the previous paragraph. The Claims Administrator will render a decision regarding the claim within

45 days after the date the Claims Administrator receives your request for review, unless the Claims Administrator, in its sole discretion, determines that special circumstances require an extension of time for reviewing the claim, in which case the Claims Administrator will render a decision as soon as possible, but not later than 90 days after the Claims Administrator's receipt of your request for review. If such an extension of time for review is required, the Claims Administrator shall furnish written notice of the extension of time to the claimant before the end of the initial 45-day period; such notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render a determination on review. The Claims Administrator may, in its sole discretion, request additional information or a meeting to clarify any matters related to the review of the claim. If you request that the Claims Administrator review your claim, you may submit written comments, documents, records and other information relating to the claim. Additionally, you shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim, provided that the Claims Administrator shall determine, in its sole discretion, whether documents, records and information are relevant to your claim, subject to applicable regulations.

In reviewing your claim, the Claims Administrator shall take into account all comments, documents, records, and other information you submit that relates to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. Additionally, the Claims Administrator's review of your claim shall not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination regarding your claim nor a subordinate of such individual. In deciding an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the appropriate named fiduciary of the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, provided that such health care professional shall not be the individual who was consulted in connection with the initial adverse benefit determination regarding the claim or a subordinate of such individual.

Disposition on Review: You will receive written notification of the Claims Administrator's decision as to the disposition of a claim submitted for review and the notice will be written in a culturally and linguistically appropriate manner and in a manner calculated to be understood by you. If your claim is denied on review, the notice shall include:

- The specific reason or reasons for the denial of the claim;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A discussion of the decision, including reasons for disagreeing with views of treating professionals, medical or vocational experts consulted, or Social Security disability determination;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits, provided that the Claims Administrator shall, in its sole discretion, determine whether documents, records and information are relevant to your claim under applicable regulations;
- The specific internal rules, guidelines, protocols, or similar criterion was relied on in making the adverse determination; a statement that a copy of such rules, guidelines, protocols, or other similar criterion will be provided to you free of charge upon request; or a statement that such internal guidelines or criteria do not exist;
- A statement of your right to bring an action under ERISA;
- A statement describing any voluntary appeal procedures;
- If the denial is based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Subrogation/Right of Reimbursement

As a condition to receiving medical, disability or any other benefits under the Plan, covered person(s), including all Dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, if a covered person received any recovery, by way of judgment, settlement or otherwise, from another person or business entity, the covered person agrees to reimburse the Plan, in first priority, for any medical, disability or any other benefit paid by it (i.e. the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by it, from any monies received, with the balance, if any, retained by the covered person). The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including medical, disability, or other expenses. Also, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the covered person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of the covered person. The Plan may enforce its reimbursement or subrogation rights by requiring the covered person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the covered person's claim without prior express written authorization by the Plan. The Plan will not be subject to any "make whole" or other subrogation rule.

Coordination of Benefits and Right of Recovery

Coordination of Benefits

Except as otherwise described in an applicable Evidence of Coverage or Benefits Booklet, in the event that a Participant is entitled to benefits from another plan or policy or medical benefits under workers compensation, benefits under this Plan may be reduced to an amount, which together with all other amounts paid under any other plan or policy, will not exceed the benefits that would in fact be eligible for reimbursement under this Plan Medicare benefits will be secondary to health plan coverage with respect to covered individuals who receive Plan coverage by virtue of current employment status during a mandatory Medicare secondary period. In all other circumstances, Medicare benefits will be primary and the Plan will coordinate with Medicare to the extent permitted under applicable law.

Right of Recovery

Whenever benefits have been paid with respect to covered expenses in a total amount at any time in excess of the amount of payment necessary, the Plan Administrator shall have the right to recover such payments to the extent of such excess from among any one or more of the following, as the Plan Administrator shall determine: (i) any persons (including, without limitation, an Employee, a Covered Dependent, a trust, or an estate) to, for or with respect to whom such payments were made, (ii) any insurance companies, or (iii) any other organizations. The Plan Administrator shall have the right to pay any amount it shall determine to be warranted to satisfy the intent of this Section to any organization making payments under other plans which should have been made under this Plan.

12. Statement of ERISA Rights

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

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as other work-sites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Receive a summary of the plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them in 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $147 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that the plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue N. W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication's hotline of the Employee Benefits Security Administration.

13. Summary of Benefits and Contributions

The Plan provides you, your Spouse, and eligible Dependents with benefits in the Plan. A summary of each benefit provided under the Plan is set forth in the attached summary plan descriptions, carrier booklets or other governing document behind the applicable Attachments.

The cost of certain benefits provided through the component benefit programs will be funded in part by Company contributions and in part by pre or post-tax Employee contributions. The Company will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time.

The Company will make its contributions in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to the insurance carrier for benefits. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using the Company's contributions to pay for the cost of such benefits.

Contributions for Coverage

Crouse Hospital pays the full cost of coverage in the following plans:

- Life and AD&D Insurance
- Short Term Disability
- Long Term Disability

You are responsible for a portion of the premium cost (as determined by the Company) for the following plans:

- Medical (including prescription drugs) (pre-tax dollars)
- Dental (pre-tax dollars)
- Vision (pre-tax dollars)
- Short Term Disability (NY-DBL) (post-tax dollars)

You are responsible for the full premium cost of coverage in the following plans:

- Voluntary Short and Long-Term Disability Buy-Up (post tax dollars)
- Voluntary Benefit Program (post-tax dollars)
- Voluntary Critical Illness (post-tax dollars)
- Supplemental Life Insurance (Employees, Spouses, Dependents) (post-tax dollars)
- Flexible Spending Account Plan (including health care and dependent care spending accounts) (pre-tax dollars)

The costs of your participation in in any benefit program offered in the Plan can be found in Attachment # 11. All plan documentation can be found in the Human Resources Department and can be provided with your written request.

With respect to benefit plans that are group health plans, the Plan will provide benefits in accordance with the requirements of all applicable laws, such as CHIPRA, COBRA, FMLA, HIPAA, HITECH, GINA, NMHPA, MHPAEA, PPACA and WHCRA.

14. Legal Compliance/Conformity

Insurance Contracts
The Director of Human Resources of Crouse Hospital may sign insurance contracts for this Plan on behalf of Crouse Hospital, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

Special Rights on Childbirth
Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally 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 the above periods. In any case, such plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Special Rights for Women
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All states of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Genetic Information Nondiscrimination Act ("GINA")
GINA prohibits employer-sponsored group health plans and health insurers providing group insurance from:

- Increasing premium or contribution amounts based on genetic information;
- Requesting or requiring an individual or family member to undergo a genetic test; and
- Requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.

Genetic information means:

- The individual's genetic tests;
- The genetic tests of family members;
- The manifestation of a disease or disorder in family members; or
- Any request for, or receipt of, genetic services or participation in clinical research that includes genetic services, by the individual or family member.

Genetic information does not include information about the sex or age of any individual. It does include, with respect to a pregnant woman, an individual who is utilizing an assisted reproductive technology, or a family member, genetic information of any fetus carried by the pregnant woman or of any embryo legally held by the individual or family member.

Mental Health Parity and Addiction Equity Act ("MHPAEA")
MHPAEA prohibits financial requirements and treatment limits for mental health and substance use disorder benefits that are more restrictive than the predominant financial requirement or treatment limit that applies to all or substantially all medical and surgical benefits.

Treatment limits include limits on the scope and duration of treatment.

The MHPAEA regulations set out a framework for assessing compliance with respect to financial requirements such as deductibles and coinsurance and quantitative treatment limits (e.g. day and visit limitations).

When the plan provides a mental health or substance use disorder benefit in any of the following six classifications, mental health and substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

The Plan is prohibited from providing a more restrictive financial requirement or treatment limit than the predominant level that applies to all or substantially all medical/surgical benefits on any mental health or substance use disorder benefit within each of the above classifications.

Non-Assignment of Benefits
Except as may be required pursuant to a "Qualified Medical Child Support Order" which provides for Plan coverage for an alternate recipient, no participant or beneficiary may transfer, assign or pledge any Plan benefit.

Continuation and Conversion Rights
If you receive health care benefits under the Plan, you may have the right to continue to receive these benefits even if your normal coverage under the Plan ends and if you have exhausted your rights under COBRA. In addition, if any of your health care benefits and life insurance benefits is provided through insurance, you may have the right to convert your coverage for those benefits from the group policy to an individual policy. If you would like more information regarding your benefit continuation or conversion rights, please contact the insurance company.

Plan's Failure to Follow Procedures
If the Plan fails to follow the claims procedures described above, a claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

No clerical error made by the Plan Sponsor, Plan Administrator, or the Claims Administrator in keeping records pertaining to this coverage or delays in making entries in such records will invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. Upon discovery of any error, an equitable adjustment of any benefits paid will be made. If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, an equitable adjustment of contributions will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under the Plan and its amount.

Effect on Workers' Compensation
The Plan is not intended to be and is not in lieu of any Workers' Compensation Act insurance and does not affect any requirement for Workers' Compensation Act insurance coverage.

Law of Governing Venue
This Plan shall be interpreted, construed, and administered in accordance with applicable state or local laws to the extent such laws are not preempted by federal law. If any provision of the Plan Document or Plan is contrary to any law to which it is subject, the provision is hereby automatically changed to meet the law's minimum

requirement. Any actions related to this Plan shall be brought in the federal or state courts located in the State of New York.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under component benefits of the Plan more than six years after the final review/appeal decision by the Plan Administrator or Claims Administrator has been rendered (or deemed rendered).

Other Circumstances that May Affect Benefits

Denial or Loss of Benefits

An Eligible Employee's benefits (and the benefits of his or her eligible spouses, and dependents) will cease when the Employee's participation in the Plan terminates (that is, when coverage ends). Benefits also cease upon termination of the Plan. In both instances, expenses incurred before coverage ended generally remain payable.

Other Circumstances

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, benefits may be denied based on lack of medical necessity. The group insurance contracts provide additional information.

15. Definitions

AD & D means accidental death and dismemberment insurance.

Claim Fiduciary means having the authority and responsibility to adjudicate claims in accordance with the provisions of the Plan. In the event a member appeal for review of a denied claim, the Claim Fiduciary makes the final determination as to whether the claim is covered. Crouse Hospital cannot overrule this determination.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Company means Crouse Hospital, its successors in interest, the sponsor of this Plan.

Dependent – Medical Coverage - means any child (including adopted child(ren), child(ren) under court-appointed guardianship, or step-child(ren) living with the Employee) who has not reached the age of 26 as provided by the Patient Protection and Affordable Care Act of 2010. Coverage in the medical (including prescription drugs) program will terminate at the end of the month in which the dependent reaches their 26th birthday. Coverage in the dental and vision benefit programs will end on the day the dependent reaches their 26th birthday.

A child who is unmarried, incapable of self-sustaining employment, and dependent upon the employee for support due to a mental and/or physical disability and considered to be totally disabled, and who was covered under the Plan prior to reaching the limiting age or due to other loss of dependent's eligibility and who lives with the employee, will remain eligible for coverage under the Plan beyond the date coverage would otherwise end.

To cover a child under this provision, the Plan Administrator must receive proof of incapacity within 31 days after coverage would otherwise terminate. The Plan Administrator may require at reasonable intervals during the two (2) years following the dependent's reaching the limiting age, subsequent proof of the child's total disability and dependency.

Your eligible Dependents can be enrolled in medical (including prescription drugs), vision and dental coverage under the Plan only if the Eligible Employee is enrolled.

The following individuals are not eligible for medical (including prescriptions drugs), vision or dental coverage, regardless of whether they are tax dependents of the employee:

- A Spouse or a child living outside the United States; or
- A parent of you or your Spouse.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; or any person who is covered under the Plan as an Employee.

Dependent – Dental and Vision Coverage - means any individual who is:

(a) an unmarried child of a Plan participant if the child is under age 19 and is primarily dependent on the participant for support;

(b) an unmarried child of a Plan participant if the child is age 19 or over, by the end of the month in which the dependent attains age 25 (limiting age) for coverage, a full-time student in regular attendance at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on (verification of full-time status is required), and primarily dependent on the participant for support;

(c) any child of a Plan participant if the child is mentally or physically incapable of self-support and is dependent upon the participant for support, regardless of the child's age, provided such mental or physical condition

commenced prior to the attainment by the child of age 19, or by the end of the calendar year in which the dependent attains age 25 (limiting age) for coverage if the child was age 19 or over and enrolled as a full-time student at the date of such commencement (verification of full-time status is required);

(d) any child of a participant who does not qualify as a dependent under subsections (a), (b), or (c) above, solely because the child is not primarily dependent upon the participant for support so long as over half of the support of the child is received by the child from the participant pursuant to a multiple support agreement;

(e) any other individual who is a dependent of the Plan participant described in Section 152(a) of the Internal Revenue Code and whose welfare is the legal responsibility of the Plan participant pursuant to legal guardianship, written divorce settlement, written separation agreement or a court order.

Full-time student coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter and maintains full-time student status the entire semester. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

Michelle's Law allows for continuation of coverage for college students during a medical leave. Under this law, a group health plan must continue to provide coverage to a dependent that otherwise would lose coverage under the plan for failing to maintain full-time enrollment in a post-secondary institution in the event the dependent requires a medically necessary leave of absence. To qualify for coverage under the law, the dependent must suffer from a serious illness or injury and lose eligibility due to the medically-necessary leave. The dependent's treating physician is required to certify that the dependent is suffering from a medical illness or injury and that the leave of absence is medically necessary. Coverage under Michelle's Law must be extended for at least one year; however, coverage may end earlier for certain reasons such as aging out of the plan (i.e. exceeding the Plan's normal dependent-eligibility age). Please see the Plan Administrator for necessary forms in the event your dependent child is entitled to extended coverage under this law.

Dependent Care Spending Account ("DCAP") means an account in the Flexible Spending Account Plan that is authorized by Section 129 of the Internal Revenue Code and reimburses eligible dependent care expenses. The Dependent Care Spending Account operates under Section 125 Cafeteria Plan rules of the Internal Revenue Code and allows payments for certain benefits on a pre-tax basis.

Eligible Employee means any part or full-time individual employed by the Employer or Affiliated Employer as a common law employee. An individual shall be considered to be employed by the Employer or Affiliated Employer as a common-law employee only if the Employer or Affiliated Employer withholds income tax on any portion of his or her income and Social Security contributions are made for him or her by the Employer or Affiliated Employer, and such individual is determined by the Employer or Affiliated Employer to be a common-law employee for purposes of the Employer's or Affiliated Employer's payroll records. It is expressly provided that any individual who is treated as an independent contractor, seasonal, or temporary by the Employer or Affiliated Employer and any other common-law employee not described above is not an Employee and is not eligible to participate in this Plan. Any individual who is retroactively or in any other way held or found to be a "statutory" or "common-law employee" of the Employer or Affiliated Employer will not be eligible to participate in the Plan for any period he or she was not contemporaneously treated as a common-law employee by the Employer or Affiliated Employer.

Employee means an employee of the Employer.

Employer means Crouse Hospital, any of its Affiliates, and any other persons, firms, or organizations that have expressly adopted this Plan with the consent of Crouse Hospital.

Enrollment Period means such period of time prior to the beginning of the Plan Year as may be specified by the Plan Administrator and communicated to Eligible Employees during which Eligible Employees and Participants may elect, or reject, to participate in the Plan.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

GINA means the Genetic Information Nondiscrimination Act of 2008.

Health Care Flexible Spending Account means a type of self-insured ERISA welfare benefit plan that reimburses eligible medical expenses that are not reimbursed through other sources. Section 125 Cafeteria Plans are authorized by Section 125 of the Internal Revenue Code and allows payments for certain benefits on a pre-tax basis.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Insurance Policy means the Policy providing such insurance coverage to Employees as may be agreed upon between the Employer and Insurer.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

NMHPA means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

Participant is a person covered under this Plan or the legal representative or guardian of a minor or incompetent person covered under this Plan.

Plan means the Crouse Hospital Welfare Benefits Plan.

Plan Year is the twelve-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year, which is a short Plan Year.

Qualified COBRA Beneficiary means an individual, on the day before a Qualifying Event, is a Spouse or dependent child of an Employee and who is covered under the medical (including prescription drugs), vision or dental coverage. In the case of a Qualifying Event, Qualified Beneficiary means an individual who on the day before the Qualifying Event is an Employee.

Qualifying COBRA Event means any of the following events: (a) death of an Employee; (b) the voluntary or involuntary termination (other than by reason of gross misconduct) of an Employee; (c) a change in an Employee's status to an ineligible status; (d) divorce or legal separation of an Employee from his or her Spouse; (e) an Employee's commencement of entitlement to coverage under Medicare or a similar governmental benefit plan; (f) a dependent child ceasing to be a dependent child under the terms of the Employer's Plan.

Pre-Tax Salary Reduction means a separate written authorization of the Employee to have his or her after-tax salary reduced in exchange for the Employer making equivalent pre-tax contributions on the Employee's behalf directly to the Insurer to pay for the level of insurance coverage elected by the Employee and his Dependents in the Plan.

Spouse means the Spouse is an Employee's husband or wife married under a legally valid marriage including common law marriage in States where it is recognized The term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

Statutory Leave means an unpaid leave of absence under the Family and Medical Leave Act or the Uniform Services Employment and Reemployment Rights Act.

Variable Hour Employee means, based on facts and circumstances, it cannot be determined the Employee is reasonably expected to work on average at least 30 hours per week.

Welfare Program means a written arrangement (including any insurance contract between an employer and an insurance company, health maintenance organization (HMO), administrative services organization (ASO), or other similar organization to provide benefits, a plan document or other instrument under which a welfare plan is established and operated ("welfare program document")) incorporated into this Plan that is offered by the Company and/or an employer which provides any employee benefits that would be treated as an "employee welfare benefit plan" under Section 3(1) of ERISA if offered separately.

Welfare program also means any plan established pursuant to Section 125 of the Code, incorporated herein. Each welfare program under the Plan is identified in this document. The Plan Administrator may add or remove a welfare program from the Plan by amending the Plan.

WHCRA means the Women's Health and Cancer Rights Act of 1998, as amended.

Exhibit A

Section 125 / Cafeteria Plan Benefits –

Flexible Spending Account Plan:
Health and Dependent Care Spending Accounts

Before Tax Savings
When you elect to make contributions to the Health or the Dependent Care Flexible Spending Account or elect to pay premiums under the Medical, Dental or Vision Plan with before-tax payroll reductions, you save the federal income tax and the Social Security tax that would ordinarily be deducted from your paycheck as a result of that compensation.

Please consult your tax advisor on whether these amounts are taxable by municipal taxing authorities.

Examples of Tax Advantages When Participating in the Plan
You are married and have one child. The Employer pays for 80% of your medical insurance premiums, but only 40% for your family. You pay $2,400 in premiums ($400 for your share of the Employee-only premium, plus $2,000 for family coverage under the Employer's medical insurance plan). You earn $50,000 and your Spouse (a student) earns no income. You file a joint tax return.

	If you participate in the Cafeteria Plan		If you do not participate in the Cafeteria Plan
1. Gross Income	$35,000		$35,000
2. Salary Reductions for Premiums	($2,400) (pretax)		$0
3. Adjusted Gross Income	$32,600		$35,000
4. Standard Deduction	($24,000)		($24,000)
5. Exemptions	$0		$0
6. Taxable Income	$8,600		$11,000
7. Federal Income Tax (Line 6 x applicable tax schedule)	0		0
8. FICA Tax (7.65% x Line 3 Amount)	($2,494)		($2,678)
9. After-tax Contributions	($0)		($2,400)
10. Pay After Taxes and Contributions	$30,106		$29,922
11. Take Home Pay Difference	$184		

Wages which are reported to the Social Security Administration (SSA) will not include your payroll reductions under the Section 125 Cafeteria Plan. Wages reported to the SSA are eventually used to determine the average compensation on which your Social Security benefit is based. Consequently, you may have a slightly reduced Social Security retirement or disability benefit. This will happen if your taxable wages after before-tax contributions are less than the Social Security taxable wage base ($137,700 indexed for 2020). However, the current tax advantages should more than offset any reduction in your Social Security benefit.

Flexible Spending Accounts
If you contribute to the Flexible Spending Account Plan (including health care or dependent care) the Company will establish an account in your name under the applicable plan(s). Your contributions for medical expense reimbursement will be allocated to your health flexible spending account (general purpose or limited purpose), your contributions for dependent care assistance will be allocated to your dependent care flexible spending account. You may contribute before-tax dollars to any or all accounts.

Any eligible medical, dental, hearing and/or vision expenses that you incur may be reimbursed from your medical flexible spending account. Any eligible dependent care expenses may be reimbursed out of your dependent care flexible spending account. Amounts cannot be transferred from one flexible spending account to the other.
When you elect to contribute an amount to health or dependent care, the Company will deduct the amount you have elected to contribute and allocate that amount in the account you have chosen. When you incur an eligible health or dependent care expenses, you are reimbursed from the appropriate account.

Contributions for Health and Dependent Care Spending Accounts
Generally, you may contribute a minimum of $100 (minimum) and up to a maximum of $2,750 (this number is adjusted for inflation after 2019) each year to your Health Spending Account. You may contribute up to a maximum of $5,000 (or up to $2,500 if you are married and file separate tax returns) to the Dependent Care Spending Account each year. However, see the tax related sections below regarding the amount of tax-free reimbursement you can receive from the dependent care account each year.

Eligible medical expenses that exceed my account balance
You may be reimbursed from your health spending account up to the total amount you have elected to contribute for the Plan Year, even if the balance in your health spending account is less than the elected amount at the time you request the reimbursement.

Eligible dependent care expenses that exceed my account balance
Unlike your health care account, you will only be reimbursed up to the balance in your dependent care account at the time of your request for reimbursement. Any eligible expenses exceeding your balance will automatically be reimbursed as new contributions are added to your account.

Balance at the end of the year
The Flexible Spending Account Plan operates on a Grace Period Plan Year extension, permitting you to incur and submit expenses up to two (2) months and 15 days in the next Plan Year (March 15th). The use-it-or-lose-it rule requires that any money left over after you've been reimbursed for all of your eligible expenses during a particular Plan Year, including the Grace Period Plan Year, must be forfeited. The money in your account may not be carried forward into the next Plan Year. Any benefit election that you decide to make should be based strictly on expenses that you are certain to have during the Plan Year covered by your election.
You may file claims incurred in the Plan Year by March 31st after the end of the Plan Year, including the Grace Period Plan Year extension.

Reimbursable medical account expenses
Generally, only expenses which are considered by the Internal Revenue Service to be tax-deductible medical expenses are considered eligible for reimbursement under the medical account, with the exception of premiums paid for other health plan coverage (including Medicare or plans maintained by the Company or the employer of your Spouse or Dependent) and certain long-term care expenses. Eligible expenses include those expenses for the diagnosis, treatment and prevention of disease, prescription drugs and insulin. Of course, medical expenses reimbursed through your health care account cannot be claimed as an additional deduction for income tax purposes. Expenses must be incurred on behalf of you, your Spouse and any Dependent with respect to whom you are entitled to claim a deduction on your federal income tax return (without regard to the earned income limit that applies for income tax purposes).

Refer to IRS Publication 502, "Medical and Dental Expenses," (available on the IRS' website at www.irs.gov) for more information regarding eligible and ineligible medical expenses, subject to the caveats in the preceding paragraph.

If you receive a reimbursement from your Health Care Spending Account and reimbursement for the same expense through your medical (including prescription drugs), dental or vision, or another health plan, you must refund the reimbursement you received from your Health Spending Account to the Plan.

Eligible expenses reimbursable from dependent care spending accounts

Generally, reimbursable expenses include day-care costs for children and dependent adults; provided such expenses are necessary in order for you and your Spouse to work or attend school full-time. (A special rule applies if your Spouse is physically incapacitated.).

If the dependent is a child, the following rules also apply:

The child must be younger than 13, lives with you for more than one-half of the calendar year and does not provide more than one-half of his or her own support for the year;

Care may be provided either inside or outside your home, but it may not be provided by anyone considered your dependent for income tax purposes or one of your children under age 19;

If the care is provided by a facility that cares for more than six children, the facility must be licensed.

If the dependent is an adult or an older dependent child, the following rules also apply:

The dependent must be physically or mentally incapable of caring for him or herself;

He or she must either be your spouse or be dependent upon you for at least 50% of his financial support;

He or she must live with you for more than one-half of the calendar year;

He or she must not have gross income in excess of a specified amount; this does not apply to a spouse.

He or she must not be someone else's "qualifying child" for federal income tax purposes;

Care may be provided either inside or outside your home; however, expenses outside of your home (e.g., at a nursing home) are eligible only if the dependent regularly spends at least eight hours each day in your household.

To make sure your situation and the type of care being provided meets IRS requirements refer to IRS Form 2441 and IRS Publication 503, "Child and Dependent Care Expenses."

Dependent care provider in your home

If you use a dependent care provider inside your home you may be considered the employer of that individual and may be responsible for withholding and paying employment taxes. For more information, refer to IRS Publication 926, "Employment Taxes for Household Employees." These forms and publications are available on the IRS' website (www.irs.gov), and also should be available at your local post office or public library.

Reimbursements under the health care and dependent care account and taxation

Amounts paid to you under the Flexible Spending Account Plan are intended to be tax-free to you and no taxes will be withheld from any reimbursement. However, special rules applicable to the dependent care account may cause some reimbursement to be taxable to you. Federal law provides that the amount of dependent care reimbursement excluded from your gross income cannot exceed the lesser of:

- $5,000 ($2,500 if you are married and filing separate federal income tax returns);
- Your annual income; or
- Your spouse's annual income.

If your Spouse is (1) a full-time student for at least five months during the year or (2) physically and/or mentally handicapped, there is a special rule to determine his or her annual income. To calculate the income, determine your Spouse's actual taxable income (if any) earned each month that he or she is a full-time student or disabled. Then, for each month, compare this amount to either $250 (if you claim expenses for one dependent) or $500 (if you claim expenses for two or more dependents). The amount you use to determine your Spouse's annual income is the greater of the actual earned income or these assumed monthly income amounts of either $250 or $500. By making an election under the Plan to contribute to a dependent care account, you are representing to the Employer that your contributions to the Flexible Spending Account Plan dependent care account are not expected to exceed these limits.

If you are married and filing separate federal income tax returns, the $2,500 limit described above will not apply

if you are (1) legally separated or (2) your Spouse did not reside with you for the last six (6) months of the calendar year, you maintained a household that was your dependent's primary residence for more than six (6) months during the year and you paid more than half of the expenses of that household.

To qualify for tax-free treatment, you are required to list on your federal income tax return the names and taxpayer identification numbers of any person who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. The identification number of a care provider who is an individual and not a care center is that individual's social security number. Your care provider should be made aware of this reporting requirement.

Other income tax considerations affecting participation in the dependent care account
You should be aware that there is a dependent care tax credit and an earned income credit.

The Federal Dependent Care Tax Credit
Dependent care expenses for which you are reimbursed from your dependent care account will not qualify for the federal tax credit available with respect to dependent care expenses. Under the Internal Revenue Code, you are entitled to a dollar for dollar credit against your income tax liability in an amount equal to a specified percentage of your qualifying dependent care expenses. For purposes of the credit, there are limitations on the dollar amount of qualifying dependent care expenses that can be taken into account. These limitations are reduced dollar for dollar by dependent care expenses reimbursed under the Dependent Care FSA. In addition, these expenses cannot be taken into account to the extent they exceed the lesser of your or your spouse's earned income.

Therefore, you must determine whether it is more advantageous for you not to establish a dependent care account in order to avail yourself of the federal tax credit. In making this determination, it is important to consider that the amount of compensation you elect to reduce under the Plan is not subject to federal income tax, but also is not subject to Social Security withholding tax (FICA) (7.65% up to $137,700 indexed for 2020).

As a general rule, depending upon your particular situation, paying for qualifying dependent care expenses through compensation reduction under the dependent care account will produce greater tax savings the higher your income level. ***If you are not certain as to what extent, if any, it is to your advantage to participate in the Plan, you should consult your personal tax advisor.***

The Federal Earned Income Credit
Another tax credit available under current tax law is the earned income credit. This credit also reduces dollar-for dollar the federal tax you have to pay but is calculated somewhat differently from the childcare credit described above. The credit is available to individuals with a child who is under age 19 (under age 24 if a student) or who is totally and permanently disabled. An additional credit is available to individuals with a child who is under one year old. The credit does not depend on the amount you pay in child care expenses. The earned income credit has no effect on the amount you can contribute under the dependent care account for dependent care expenses, and the earned income credit cannot be claimed for any individual for whom you claim the child care credit described above. Moreover, the use of the dependent care account may result in a reduction in your taxable income thus qualifying you for the earned income credit where you would not otherwise have qualified.

Losing coverage under the Flexible Spending Account Plan
If you elect to participate in the health care spending account, you have a right to choose continuation coverage if you lose your coverage due to a qualifying COBRA event. In general, you may only continue coverage in the amount in effect on the day before you lost coverage; you may not alter the coverage. If you lose coverage under the Plan, see the COBRA Section in this document for your rights to continue coverage in the Flexible Spending Account (Health Care Spending Account). Special continuation rules do not apply to any dependent care account election in the Flexible Spending Account Plan.

Special rules for highly compensated and key employees

Under the Internal Revenue Code, certain employees are considered “highly compensated employees” and “key employees”. To prevent discrimination in favor of these employees, the Plan Administrator may limit or reduce their contributions in a uniform and nondiscriminatory manner. If you are a highly compensated and/or a key employee, the Plan Administrator will notify you if it becomes necessary to modify the amount of your contributions.

Incorrect amounts in connection with the Plan
It will be assumed that all payments to you are excludable for federal and state income tax purposes and no taxes will be withheld. It is your obligation to determine whether each payment is actually excludable from your gross income for such purposes.

If you receive any payment or reimbursements under the Flexible Spending Account Plan that are not warranted, justified or correct, you will indemnify and reimburse the Employer for any liability which it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements.

Benefit Claims for the Flexible Spending Account Plan
You have two options for reimbursement of claims in the program: manual claims require to you to submit a Reimbursement Request Form and your receipt(s), via fax, mail, and online.

You can submit a claim for an eligible medical or dependent care expense at any time during the Plan Year.

Lifetime Benefits Solutions
333 Butternut Drive
Syracuse, NY 13214
Customer Service: 1-800-356-1029
Fax: 877-256-7228
lbscustomerservice@lifetimebenefitssolutions.com

For paper claims, you may also obtain a Reimbursement Request Form for reimbursement from the Plan Administrator. When submitting your claim form, you must also submit a copy of the original itemized bill or receipt for an expense not covered under your medical (including prescription drugs), vision or dental coverage, or the explanation of benefits from the insurance company.

In accordance with the Uniform Reimbursement Requirement for Flexible Spending Accounts under the provisions of the Internal Revenue Code, you may obtain reimbursement up to the amount you have elected (plus any available Employer contributions) to deposit into your Health Care Spending Account.

You can submit a claim for an eligible dependent care expense at any time during the Plan Year.

The money deposited in your account for the Plan Year will be used to reimburse you for eligible expenses incurred during that year only. An expense is incurred when the care is provided, and not when the bill is sent or payment is made. There is no extension of the claims incurrence period for the Dependent Care Spending Account.

Reimbursements for dependent day care expenses are allowed up to the amount actually in your Dependent Care Spending Account at the time you submit your request. If your claim for benefits exceeds the amount currently available in your Dependent Care Spending Account, you will receive additional reimbursements as more money is deposited into your account through salary reductions and through any contributions your Employer may make.

Change in Employment Status or Death of a Participant
In the event of a death of a participant, deposits stop. Your surviving dependents may submit for reimbursement, eligible expenses incurred prior to the participant’s death. Claims for eligible expenses incurred prior to the

participant's death must be submitted within 90 days following the close of the Plan Year.

If your employment status changes from an eligible to ineligible status, deposits stop at the date of the change in status. Requests for reimbursement of expenses incurred prior to the change in employment status must be submitted within 90 days following the close of the Plan Year.

Denial of benefit in the Flexible Spending Account Plan

The following information is provided regarding claims and review procedures for benefit plans that are covered by the Employee Retirement Income Security Act ("ERISA"). It is based upon regulations issued by the U.S. Department of Labor. The Health Care Spending Account under this Plan is a benefit that is covered by ERISA. If your claim for health care account benefits is denied by the Plan Administrator or Third-Party Administrator, you will be notified of this, in writing, within thirty-one (31) days after receipt of your claim. If the Plan Administrator or Third-Party Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Plan Administrator or Third-Party Administrator will notify you within the initial thirty-one (31) day period that the Plan Administrator or Third-Party Administrator needs up to an additional fifteen (15) days to review the claim. If such an extension is necessary because you failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that you will need to provide to the Plan Administrator or Third-Party Administrator. You will have no less than forty-five (45) days from the date you receive the notice to provide the requested information.

If your claim for dependent care account benefits is denied by the Plan Administrator or Third-Party Administrator, you will be notified of this, in writing, within ninety (90) days (or one hundred eighty (180) days under special circumstances) after receipt of your claim.

The written notice of denial will include the following information:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claimant to perfect his or her claim and an explanation as to why such information is necessary;
- in the case of a medical account claim, a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the determination or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge at the claimant's request; and
- a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that the claimant is eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal).

If an initial claim for benefits is denied by the Plan Administrator or Third Party Administrator, you or your duly authorized representative may appeal the denial by filing a written request with the Plan Administrator or Third Party Administrator within sixty (60) days (in the case of a dependent care account claim) or one hundred eighty (180) days (in the case of a medical account claim) after receipt of the notice denying the initial claim for benefits. Upon your decision to appeal a denied claim for benefits, you or your duly authorized representative will be able to submit written comments, documents, records, and other information relating to his or her claim for benefits (regardless of whether such information was considered in the initial claim for benefits) to the Plan Administrator or Third-Party Administrator for review and consideration. You or your duly authorized representative will be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to the appeal.

Upon receipt of your appeal of a denied claim for benefits, the Plan Administrator or Third-Party Administrator will respond to the claim within sixty (60) days (or one hundred twenty (120) days in the case of a dependent care account claim), after receipt of the appeal.

If the Plan Administrator or Third-Party Administrator denies the claim (in whole or in part), the Plan Administrator

or Third-Party Administrator will provide you or your duly authorized representative with written notice of the denial. This notice will include the following:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to the claim and/or appeal for benefits;
- in the case of a medical account claim, a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you or your duly authorized representative free of charge at his or her request; and
- a statement that the claimant is entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue his or her claim for benefits.

You must follow all the steps described above before you may consider legal action against the Plan or the Plan Administrator. Naturally, both you and the Plan Administrator will want to avoid legal action. However, if you feel that legal action is necessary, any summons or other legal documents should be served to the agent for service of legal process found in this Plan document.

The Heroes Earnings Assistance and Relief Tax Act of 2008 (the "HEART Act")

The HEART Act permits employers to allow qualified reservist distributions from medical flexible spending account programs. Distributions of unused medical flexible spending accounts to reservists called to active duty will provide an amount actually contributed to the medical flexible spending account by the employee as of the date of the distribution request, minus reimbursements received to date.

This distribution option applies to a member of a reserve component who is called to active duty for a period of 180 days or more or an indefinite period of time. The period of active duty specified in the order is used by the employer to determine the duration of the order, even if the period of active duty is later changed. However, if subsequent orders increase the total period of active duty to more than 180 days, the employee qualifies for a qualified reservist distribution.

An employee may request a qualified reservist distribution on or after the date of call to active duty and before the last day of the plan year or the applicable grace period for the plan year in which the call to active duty occurred.

The Company must pay the qualified reservist distribution to the employee within a reasonable time, but not more than 60 days after the request is made.

A qualified reservist distribution is included in the gross income of the employee and subject to employment taxes. The employer must report the amount of the distribution as wages on the employee's Form W-2 for the year in which the distribution was paid to the employee.

The employer must receive a copy of the employee's order or call to active duty prior to making the distribution.

Termination of Employment

If you terminate your employment with the Company, all claims for benefits from the Flexible Spending Account Plan incurred during your employment are reimbursable to you within 90 days of your date of termination. You must submit the appropriate claim form to the Claims Administrator for the Flexible Spending Account Plan. You may also have a right to COBRA continuation coverage for your health care spending account.

Crouse Hospital
Resolution of the Board of Directors
Amendment and Restatement of Welfare Benefit Plan

Crouse Hospital maintains certain employee welfare benefit plans providing the following benefits:

- Medical
- Prescription Drugs
- Dental
- Vision
- Life and AD&D Insurance
- Supplemental Life Insurance for Employees, Spouses, or Dependents
- Short Term Disability (NY-DBL)
- Short Term Disability (including voluntary buy-up)
- Long Term Disability (including voluntary buy-up)
- Voluntary Benefit Program
- Flexible Spending Account Plan (including health and dependent care spending accounts)

Crouse Hospital reserves the right to amend benefits listed above and in effect as the date of this Resolution. Crouse Hospital wishes to amend and restate these programs accordingly.

It is resolved that the Crouse Hospital Welfare Benefit Plan for non-union employees is hereby amended to read as set forth in the document entitled “The Crouse Hospital Welfare Benefits Plan Summary Plan Description” in substantially the form attached to this Consent.

The officers of Crouse Hospital or any one of them are authorized to execute the Plan and any and all other documents, and to take such other action, which is necessary or convenient to effectuate this resolution.

Signature:

Officer

Dates (effective date)

Attestation (witness)

Section 125 / Cafeteria Plan Benefits –
Flexible Spending Account Plan:
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