SUMMARY OF MATERIAL MODIFICATION

Benefit claim determinations made on and after April 1, 2018 (or such later date as may be determined by the Secretary under subsequent guidance or ruling) shall be based on the applicable provisions of the Department of Labor (DOL) Regulations, taking into account final DOL Regulations concerning disability claims that were issued on December 16, 2016. These provisions were adopted and are reflected in the Prototype Plan document and other documents used by the Employer or Administrator to interpret such procedures for purposes of making and ensuring such determinations are applied consistently with respect to similarly situated Claimants.

Except to the extent that an applicable collective bargaining agreement provides another method of resolving claims under the Employer's Plan, the provisions of this Section will control whenever a claim for benefits under the Plan is filed by you as an Employee, Participant or Beneficiary (a "Claimant") and is denied in whole or in part. The provisions of this Section will also control whenever a Claimant seeks a remedy under any provision of ERISA or other applicable law in connection with any error regarding his or her benefit under the Plan and such claim is denied in whole or in part.

Therefore, the subsection titled "Claims Procedures" of the Summary Plan Description is hereby amended to read as follows:

Claims Procedure

If you feel that you are entitled to a benefit that you are not receiving from the Plan, you can make a written request to the Administrator (or its delegate) for that benefit. Plan Benefits fall into two categories – Disability related benefits and non-Disability related benefits. A Disability-related benefit means a benefit that is available under the Plan and that becomes payable upon a determination of a Participant's Disability by the Administrator. A Disability-related benefit does not include a benefit that, under the terms of this Plan, becomes payable upon a determination of a Participant's Disability by the Social Security Administration or under a long term Disability plan sponsored by the Employer. The claims procedure for Disability-related benefits and non-Disability benefits are similar, but there are differences. While the claims procedure for each benefit is described below, this is just a summary, and the Administrator can supply you with a more detailed claims procedure.

Exhaustion of Remedies
No civil action for benefits under the Plan will be brought unless and until you have (1) submitted a timely claim for benefits in accordance with the provisions of this Section; (2) been notified by the Administrator that the claim has been denied; (3) filed a written request for a review of the claim in accordance with the applicable provisions of paragraphs (e) or (f) below; and (4) been notified in writing of an adverse benefit determination on review.

Grounds for Judicial Review
Any civil action will be based solely on your advanced contentions in the administrative review process, and the judicial review will be limited to the Plan document and the record developed during the administrative review process as set forth in this Section.

Written Claims
Any claim for benefits must be filed in writing with the Administrator, but the Administrator may permit the filing of a claim for benefits electronically as the Administrator complies with certain Department of Labor requirements.

Any Employee, Participant or Beneficiary who files a claim for benefits under the Plan is a "Claimant" under these claims procedures.

As a Claimant, you may authorize a representative to act on your behalf with respect to any claim under the Plan. The representative must provide satisfactory evidence to the Administrator of its authority to act on your behalf, such as a letter of authority with your notarized signature. To the extent consistent with the authority you grant to your representative, references to "you" or to "Claimant" in these claims procedures include your representative.

The Administrator may review claims under the Plan or may delegate that authority to an appropriate claims adjudicator. References in these claims procedures to the Administrator include any claims adjudicator acting on behalf of the Administrator. Benefit claim determinations shall be made based on the applicable provisions of the Plan document and any documents of general application that interpret the Plan provisions and are maintained by the Employer or the Administrator for purposes of making benefit determinations. The Administrator shall take such steps as are necessary to ensure and verify that benefit claim determinations are made in accordance with such documents and that the Plan provisions are being applied consistently with respect to similarly situated Claimants. All notices to Claimants will be written in a manner calculated to be understood by the Claimant.

Review of Non-Disability Benefit Claims

The provisions of this paragraph will apply if your claim for a benefit does not require a determination as to whether or not you are disabled or if a claim requires a Disability determination, but that determination is made outside the Plan for reasons other than determining eligibility for a Plan Benefit. Examples of this are where the Disability determination is based solely on whether you are entitled to disability benefits under either the Social Security Act or the Employer's long term disability plan.

- **Initial Denial.** Whenever the Administrator decides for any reason to deny a claim in whole in part, the Administrator will give you a written or electronic notice of its decision within 90 days of the date the claim was filed, unless an extension of time is necessary or you voluntarily agree to an extension. If special circumstances require an extension, the Administrator will notify you before the end of the initial review period that additional review time is necessary. The notice for an extension (a) will specify the circumstances requiring a delay and the date that a decision is expected to be made; and (b) will describe any additional information needed to resolve any unresolved issues. Unless the Administrator requires additional information from you to process the claim, the review period cannot be extended beyond an additional 90 days unless you voluntarily agree to a longer extension or the Administrator determines that special circumstances require a further extension. If special circumstances require a further extension, the Administrator will notify you before the end of the extended review period that further additional review time is necessary and such notice will describe the special circumstances requiring a further delay and specify the date a decision is expected to be made. The Administrator cannot extend the review period beyond an additional 90 days unless you voluntarily agree to a longer extension. If the Administrator requires additional information from you to process the claim and a timely notice requesting the additional information is transmitted to you, it must be provided within 90 days of the date that the notice is provided by the Administrator.

- **Notice of Denial.** If your claim is denied, the notice will contain the following information: (a) the specific reasons for the denial; (b) reference to the specific Plan provisions on which the denial is based; (c) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; (d) 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 your claim; (e) a description of the Plan's review (i.e., appeal) procedures, the time limits applicable to such procedures, and in the event of an adverse review decision, a statement describing any voluntary review procedures and your right to obtain copies of such procedures; and (f) a statement that if you request a review of the Administrator's decision and the reviewing fiduciary's decision on review is adverse to you, there is no further administrative review following the initial review, and that you then have a right to bring a civil action under ERISA §502(a). The notice will also include a statement advising you that, within 60 days of the date on which you receive such notice, you may obtain review of the decision as explained in the next paragraph.

- **Right to Appeal.** Within the 60-day period beginning on the date you receive notice regarding disposition of your claim, you may request that the claim denial be reviewed by filing with the Administrator a written request for such review. The written request must contain the following information: (a) the date on which your request was received by the Administrator; (b) the specific portions of the denial of your claim which you request be reviewed; (c) a statement setting forth the basis upon which you believe the Administrator's denial of your claim should be reversed and your claim should be accepted; and (d) any other written information (offered as exhibits) which you want to be considered to explain your position, without regard to whether such information was submitted or considered in the initial benefit determination.

- **Review on Appeal.** In general, your appeal will be reviewed within 60 days of the date it is received by the Administrator (unless special circumstances require an extension to 120 days and you are so notified before the end of the 60-day review period). The review will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial determination. The decision on review will contain the following: (a) the specific reasons for the denial on review; (b) reference to specific Plan provisions on which the denial is based; (c) 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 your claim; (d) a statement describing any voluntary review procedures and your right to obtain copies of them; and (e) a statement that there is no further administrative review of decision and that you have a right to bring a civil action under ERISA §502(a).

Review of Disability Benefit Claims

The provisions of this paragraph will apply if your claim for a benefit requires a determination as to whether or not you are disabled. These provisions will not apply if a Disability determination is made outside the Plan for reasons other than determining eligibility for a Plan Benefit. Examples of this are where the Disability determination is based solely on whether you are entitled to disability benefits under either the Social Security Act or the Employer's long term disability plan.

- **Initial Denial.** Whenever the Administrator decides for any reason to deny a claim for a Disability benefit in whole or in part, the Administrator will transmit to you a written or electronic notice of its decision within 45 days of the date the claim was filed, unless an extension of time is necessary or you voluntarily agree to an extension. If, prior to the expiration of the initial 45-day period, the Administrator determines that a decision cannot be made within that initial 45-day period due to matters beyond the control of the Plan, the Administrator will provide you a notice before the end of the 45-day review period that a 30-day extension of time is necessary. If, prior to the end of the first 30-day extension period, the Administrator determines that a decision cannot be made within that first 30-day extension period due to matters beyond the control of the Plan, the Administrator will provide you a notice before the end of the first 30-day extension period that an additional 30-day extension of time is necessary. Any notice of an extension of time will (a) specify the circumstances requiring the extension of time and the date a decision is expected to be rendered; (b) explain the standards on which entitlement to a Disability Benefit is based; (c) state the unresolved issues that prevent a decision on the claim; and (d) describe any additional information needed to resolve those issues. If the Administrator requires additional information from you to process the Disability Benefit claim and a timely notice requesting the additional information is transmitted to you, you must provide the additional information within 45 days of the date the notice is provided. The claims review period will be temporarily suspended until the earlier of the date you provide the required information or the end of your permitted response period.

  The notice requesting additional information may also serve as notice of a claim denial if the notice clearly states that unless you provide the requested information within the prescribed time period, the claim will be denied for failure to provide sufficient information. A combined notice must provide both the information described above and the information under *Notice of Denial* below. If you are required to provide additional information, the Administrator has discretion to decide whether to request the information and extend the initial review period as described in this section or, instead, to deny the claim on the basis that there is not sufficient information to proceed.

- **Notice of Denial.** If your claim is denied, the notice will contain the following information: (a) the specific reasons for the denial; (b) reference to the specific Plan provisions on which the denial is based; (c) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; (d) 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 your claim; (e) either (1) if the claim denial is based on an internal rule, guideline, protocol, or other similar provision, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy thereof is available upon request, free of charge or (2) an affirmative statement that the claim denial is ***not*** based on an internal rule, guideline, protocol, or other similar criterion; (f) if the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Claimant's medical circumstances, or a

statement that such explanation is available upon request, free of charge; (g) a discussion of the decision, including an explanation for disagreeing with or not following (1) the views you presented of health care professionals who treated you and vocational professionals who evaluated you; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied on in making the determination; and (3) any Disability determinations made by the Social Security Administration; (h) a description of the review (i.e., appeal) procedures, the time limits applicable to such procedures, and in the event of an adverse review decision, a statement describing any voluntary review procedures and your right to obtain copies of such procedures; and (i) a statement that if you request a review of the Administrator's decision and the review is adverse to you, that there is no further administrative review following such initial review, and that you have a right to bring a civil action under ERISA §502(a). The notice will also include a statement advising you that, within 180 days of the date you receive the notice, you may obtain review of the decision as explained in the next paragraph.

- **Right to Appeal.** Within the 180-day period beginning on the date you receive notice regarding disposition of your claim, you may request that the claim denial be reviewed by filing with the Administrator a written request for such review. The written request for such review must contain the following information: (a) the date on which your request was received by the Administrator; (b) the specific portions of the denial of your claim which you request be reviewed; (c) a statement setting forth the basis upon which you believe the Administrator's denial of your claim should be reversed and your claim should be accepted; and (d) any other written information (offered as exhibits) which you want to be considered to explain your position, without regard to whether such information was submitted or considered in the initial benefit determination.

- **Review by Alternate Reviewer.** Review of a Disability Benefit claim that has been denied under the procedures described in the preceding two paragraphs will be conducted by a reviewer who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. The reviewer will not afford deference to the initial adverse benefit determination, but will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. If the adverse benefit determination was based on a medical judgment, the reviewer will consult with an appropriate health care professional who (a) was not consulted on the original adverse benefit determination, (b) is not subordinate to someone who was consulted on the original adverse benefit determination, and (c) has appropriate training and experience in the field of medicine involved in the medical judgment. The reviewer will either (1) provide you with a list of any experts whose advice was obtained on the original adverse determination, without regard to whether the advice was relied upon in making the determination or (2) notifiy you that you may request, in writing, a list of such experts. You must also be provided reasonable access to, and copies of, all documents, records and other information relevant to your claim. No fee may be charged for such access and/or copies.

- **Review on Appeal.** In general, your appeal will be reviewed within 45 days of the date it is received by the Administrator (unless special circumstances require an extension to 90 days and you are so notified before the end of the 45-day review period). The reviewer will conduct a full and fair review of the Administrator’s decision denying your claim for benefits and will render its written decision. If the reviewer anticipates denying your appeal, whether in whole or in part, based on new or additional evidence or a new or additional rationale, the reviewer must provide you with (i) the new or additional evidence considered, relied upon, or generated by or at the direction of the Plan, the insurer, the reviewer, or any other person making the benefit determination and/or (ii) the new or additional rationale for the determination. The information must be provided to you free of charge and as soon as possible so that you have a reasonable opportunity to review the information and submit a response before the reviewer is required to render its decision. If the reviewer decides for whatever reason to deny, whether in whole or in part, your appeal of an adverse benefit determination, the reviewer's decision will be provided in a culturally and linguistically appropriate manner and contain the following: (a) the specific reasons for the denial; (b) reference to specific Plan provisions on which the denial is based; (c) 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 your claim; (d) either (1) if the claim denial is based on an internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion is available upon request, free of charge or (2) an affirmative statement that the claim denial is ***not***

based on an internal rule, guideline, protocol, or other similar criterion; (e) if the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation is available upon request, free of charge; (f) a discussion of the decision, including an explanation for disagreeing with or not following (1) the views you presented of health care professionals who treated you and vocational professionals who evaluated you; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied on in making the determination; and (3) any Disability determinations made by the Social Security Administration; (g) a statement describing any voluntary review procedures and your right to obtain copies of such procedures; and (h) a statement that you have a right to bring a civil action under ERISA §502(a).

- **Additional Levels of Appeal.** If the Plan provides additional level(s) of appeal, the Plan may not require you to file more than two appeals of an adverse benefit determination prior to bringing a civil action under ERISA Section 502(a). If the Plan offers voluntary level(s) of appeal, then (a) the Plan waives any right to assert that you failed to exhaust administrative remedies because you did not submit a benefit dispute to any voluntary level of review provided by the Plan; (b) any statute of limitations or other defense based on timeliness is temporarily suspended during the time that a voluntary appeal pursuant to the Plan's procedures is pending; (c) you may only submit a benefit dispute to a voluntary level of review if you have exhausted the appeals permitted above; and (d) the Plan provides to you, upon request, sufficient information concerning the voluntary level(s) of appeal to enable you to make an informed decision about whether to submit a benefit dispute to the voluntary level of appeal, including (1) a statement that your decisions as to whether or not to submit a dispute to the voluntary level of appeal will have no effect on your right to other benefits under the Plan, (2) information about the applicable rules, (3) your right to representation, (4) the process for selecting a decision maker, and (5) any circumstances that may affect the impartiality of the decision maker. No fees or costs may be imposed on you as part of the voluntary level of appeal.