Sheet Metal Workers Local No. 112

Retiree Health Reimbursement Arrangement (HRA) Plan

Plan Document and Summary Plan Description

This booklet is the Plan Document for the Sheet Metal Workers Local No. 112 Retiree Health Reimbursement Arrangement and is also intended to operate as your Summary Plan Description. We invite you to carefully review these Plan provisions. This booklet explains the benefits available to you and your spouse through the Plan. This Plan helps to provide financial security for you and your spouse when you are faced with large health care premium expenses. We hope this booklet will serve not only as a guide but also as evidence of our concern for the welfare of you and your spouse.

This booklet is not an employment contract or an offer to enter into an employment contract. Plan benefits and rights to Plan benefits will never vest. This Plan is subject to ERISA. For more information on your rights as a participant under this Plan, see the section entitled "Statement of ERISA Rights".

It is our intention to continue the Plan indefinitely and to make contributions to the Plan. However, we reserve the right to amend the Plan at any time and will notify you within 60 days after the effective date of any Plan amendment that would reduce any benefit. We also reserve the right to terminate the Plan at any time provided that we have given you at least 60 days advance notice of our intention to do so. Should the Plan be terminated for any reason, the assets of the Plan, if any, will continue to be used to provide benefits for premium expenses received before the date of the termination, in the order received, until such time as the assets, if any, are exhausted.

If you have any questions relating to Eligibility, classification or coverage under the Plan, submit them to the Plan Administrator.

Sheet Metal Workers Local No. 71
Retiree Health Reimbursement Arrangement (HRA) Plan
and Summary Plan Description

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Sheet Metal Workers Local No. 112
Retiree Health Reimbursement Arrangement (HRA) Plan

ARTICLE I. INTRODUCTION

1.1 General Plan Information

PLAN NAME:	Sheet Metal Workers Local No. 112 Retiree Health Reimbursement Arrangement Plan
EMPLOYER IDENTIFICATION NO:	16-6052225
TYPE OF PLAN:	This Plan is an employee welfare benefit plan and a health reimbursement arrangement as described in IRS Notice 2002-45. Your benefits are based upon the amount of money in your account, which consists of contributions made by your Employer.
PLANSPONSOR, PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS:	Board of Trustees/Sheet Metal Workers Local No.112 Welfare Fund 1200 Clemens Center Parkway P.O. Box 1146 Elmira, New York 14902-1146 (607) 733 -9621
SOURCES OF CONTRIBUTIONS:	Sheet Metal Workers Local #112 Welfare Trust Fund
TYPE OF ADMINISTRATION:	Self-Insured Welfare Fund
PLAN YEAR:	Plan records are kept on a Plan Year basis beginning on January 1st and ending December 31st.
SOURCE OF FUNDING:	Benefits are paid from the assets of the Plan and trust established and funded in accordance with the collective bargaining agreement between the Sheet Metal Workers Local 112 and its contributing employers

1.2 Establishment of the Plan

The Board of Trustees, Sheet Metal Workers Local No. 112 Welfare Fund (the "Trustees") hereby establish the Sheet Metal Workers Local No. 112 Retiree Health Reimbursement Arrangement (HRA) Plan (the "Plan") effective January 1, 2021 (the "Effective Date"). Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

1.3 Legal Status

This Plan is intended to qualify as an employer-provided, retiree-only, medical reimbursement plan under Internal Revenue Code §§105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and will be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from participating Employees' gross income under Code 105(h).

ARTICLE II. DEFINITIONS

2.1 Definitions

"Benefits" means the reimbursement benefits for Premium Expenses described under Article V.

"Trustees" means the Board of Trustees of the Fund.

"Business Associate" means a person or organization, other than one which is a member of the Plans workforce, that has a direct contractual relationship with the Plan and which receives, uses, discloses, or maintains Protected Health Information for the Plan.

"Claim Administrator" means the person or entity appointed by the Plan Administrator to process Medical Care Expense claims. In the event a Claims Administrator has not been appointed or resigns, the Plan Administrator shall be deemed to be the Claims Administrator. The Plan Administrator may designate itself as Claims Administrator at any time.

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

"Code" means the Internal Revenue Code of 1986, as amended.

"Dependent" Any individual who is a tax dependent of the Participant as defined in Code 152, with the following exception: any child to whom Code 152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents. Notwithstanding the foregoing, the HRA Account will provide benefits in accordance with the applicable requirements of any QMSCO, even if the child does not meet the definition of "Dependent." A child of a Participant shall be considered a "Dependent" up to the end of the Plan Year in which he or she turns age 26, in accordance with Internal Revenue Service Notice 2010-38.

"Electronic Protected Health Information (Electronic PHI)" means Protected Health Information that is transmitted by or maintained in electronic media.

"Employee" means any person employed by an Employer under a Collective Bargaining Agreement.

"Employer" means an employer contributing to the Sheet Metal Workers Local No. 112 Welfare Fund pursuant to a collective bargaining agreement with Sheet Metal Workers Local No. 112.

"ERISA" means the Employee Retirement Income Security Act of 1974, as presently enacted and as it may be amended from time to time, together with its related rules and regulations.

"Enrollment Date" of this Plan has the meaning described in Article IV.

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

"Marketplace Exchange" means the online marketplaces for health insurance.

"HRA" means a health reimbursement arrangement as defined in IRS Notice 2002-45.

"Medical Care Expenses" means expenses incurred by you, or your Spouse or Dependents for medical care, as defined in Code 213(d). Reimbursements due for Medical Care Expenses incurred by you or your Spouse or Dependent(s) will be charges against your HRA account.

"Participant" means a person who is an eligible Retiree, who is participating in this Plan in accordance with the provisions of Article III, and who has not for any reason become ineligible to participate further in the Plan.

"Period of Coverage" means the period of time in which an individual is a Participant in the Plan.

"Plan" means Sheet Metal Workers Local No. 112 Retiree Health Reimbursement Arrangement as set forth herein and as amended from time to time.

"Plan Administrator" means the Board of Trustees, Sheet Metal Workers Local No. 112 Welfare Fund or any entity, individual or Committee designated by the Plan Administrator as having full authority to act on behalf of the Plan Administrator, subject to any limitations established by the Plan Administrator, as described in Article VII.

"Plan Year" means the 12-month period beginning on January 1 and ending on December 31.

"Privacy Officer" means the person(s) designated by the Employer who is responsible for development, implementation, and compliance with the privacy policies and procedures as required by HIPAA.

"Protected Health Information (PHI)" means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an 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; and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. Protected health information includes information of persons living or deceased.

"Qualified Health Plan" shall mean an insurance plan that is certified by the Marketplace Exchange, provides essential health benefits, and follows established limits on cost-sharing. For more information refer to 42 USC 18021 (a).

"Qualified Medical Child Support Order (QMCSO)" means any judgment, decree, or order (including approval of a property settlement agreement) issued by either a court of competent jurisdiction or through an administrative ruling that has the force and effect of state law. To be qualified, a QMCSO must satisfy the requirements of Section 609 of ERISA.

"Retiree" means the person(s) who has retired from the bargaining unit of Employees covered by a Collective Bargaining Agreement between an Employer and Sheet Metal Workers Local No. 112 Sheet Metal Workers Local No. 112 Pension Fund.

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

"Standard Transaction" means a transmission of information in a predetermined format between two or more parties to carry out financial or administrative activities related to the use and disclosure of Protected Health Information as required by the HIPAA Privacy Regulation.

"Surviving Spouse" or "Surviving Dependent" means a spouse or Dependent who is a Covered Dependent under this Plan on the date of an Employee's death.

"Treatment, Payment, or Health Care Operations" means the medical, financial, or administrative activities required before the Plan can determine benefits including, but not limited to, the application of Standard Transactions, receipt of health care claims, health care payments, enrollment and disenrollment in the Plan, referral certification and authorization, and coordination or management of health care or related services by a Provider.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

You are eligible to participate in this Plan if you satisfy the definition of a Retiree who has elected the Sheet Metal Workers Local No. 112 Retiree Health Reimbursement Arrangement (HRA). Once the Trustees have determined that you have met the Plan's eligibility requirements, your coverage will commence.

This Plan is offered to you when you are a Retiree and no longer entitled to coverage under the Local #112 Sheet Metal Workers Health Care Plan (the "Health Plan"), through COBRA or otherwise.

3.2 Dependent Eligibility

Spouse and Dependent coverage. Coverage will be available to you and your Spouse only. Your Spouse becomes covered on your Enrollment Date, provided that you enroll in coverage for your spouse. Your Dependent(s) are not eligible for coverage, unless a Qualified Medical Child Support Order (QMCSO) is submitted. See section 9.5 for more details on QMCSO's.

3.3 Termination of Participation

Your, and your spouse's, participation in this Plan will cease upon the earlier of:

- the termination of this Plan; or
- you no longer meet the definition of Retiree; or
- your death

Reimbursements from the Plan after termination of participation will be made pursuant to Section 5.5.

3.4 Opt-Out Provision

You may choose to opt-out of this Plan at any time, provided that you provide the Plan Administrator with a written statement of your decision to waive all future reimbursements under the Plan.

3.5 Re-Employment

If you are re-employed by a contributing Employer to the Sheet Metal Workers Local No. 112 Welfare Fund, your HRA account will be frozen. Any expenses incurred during your re-employment will not be reimbursable under your HRA.

ARTICLE IV. METHOD AND TIMING OF ENROLLMENT

4.1 Enrollment Date

You will be eligible to participate in this plan when you reach Retiree status. Your participation in the Plan will begin on the Enrollment Date of the plan. Your Enrollment Date will be the first day of the

month after your retirement, provided you have elected to waive COBRA coverage from the Health Plan. Once enrolled, your participation will continue until your participation ceases pursuant to Section 3.3.

ARTICLE V. HEALTH REIMBURSEMENT BENEFITS

5.1 Benefits

Under the Plan you will receive reimbursement for any covered Medical Care Expenses that you, your Spouse or your eligible Dependents incur. Medical Care Expenses are considered "incurred" at the time the drugs, medical equipment, or medical care service is provided, not at the time you pay for them. The amount available to reimburse your Medical Care Expenses at any given time is limited to your remaining HRA account balance.

Medical Care Expenses can only be reimbursed to the extent that you or the other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable). If only a portion of a Medical Care Expense has been reimbursed elsewhere the HRA account can reimburse the remaining portion of such Medical Care Expense if it otherwise meets the requirements of the Health Reimbursement Benefits Section.

You are generally eligible to receive benefits from the Plan upon your Enrollment Date.

5.2 Premium Tax Credit Exclusion

The Affordable Care Act (ACA) offers individuals who purchase individual coverage, through the Marketplace Exchange, a premium tax credit. Individuals who are covered by a standalone Health Reimbursement Account are not eligible to receive this tax benefit if the participant's HRA account is funded. Therefore, Participants in this Plan are NOT eligible to receive the federal premium tax credit granted by the ACA for any month in which they are covered by this HRA. If you wish to gain eligibility for the premium tax credit you must waive future reimbursements in accordance to Section 3.4 of this Plan.

5.3 Establishment and Funding of Account

When you become a Participant in accordance with Articles III and IV, the Plan Administrator will establish and maintain your HRA Account but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

Your HRA account will be credited on your Enrollment Date with an amount equal to the balance in your HRA account under the Local #112 Sheet Metal Workers Health Reimbursement Arrangement.

(b) *Debiting of Accounts*. Your HRA account will be debited for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.

(c) Available Amount. The amount available for reimbursement of Medical Care Expenses is the amount credited to your HRA Account under subsection (a) reduced by prior reimbursements debited under subsection (b).

(d) *Carry Over of Account*. If any balance remains in your HRA account after all reimbursements have been made for a Plan Year, that balance will be carried over to reimburse you for Medical Care Expenses incurred during a subsequent Plan Year. The balance in your HRA Account will be

forfeited and added to the Fund's reserves at the end of a period of twenty-four (24) consecutive months in which there is no distribution from your HRA Account. Further, any balance remaining in your HRA Account upon your death (if you are not survived by a spouse or eligible Dependents), or upon the death of the survivor of your spouse or eligible Dependents, will be forfeited and added to the Fund's reserves.

5.4 Reimbursement Procedure

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

- You may use the debit card issued under this Plan or you must submit a claim to the Claims Administrator and provide any additional information requested by the Claims Administrator;
- A request for payment must relate to the Medical Care Expenses incurred during the time you were covered under this Plan; and
- Claims must be submitted in writing (unless a debit card is used).

Claims may be submitted directly to the Claims Administrator:

ProFlex Administrators, LLC
8321 Main Street
Williamsville, NY 14221
Phone - 716-633-2073
Fax - 716-929-2013
www.proflextpa.com

- Complete a Claim Form, found at www.proflextpa.com, and attach additional information as required.
- You will be reimbursed directly for Medical Care Expenses.

The claim or in the case of a debit card transaction where the Plan has requested additional information the documentation must set forth:

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

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

If you use a debit card, you must certify that the debit card will only be used to pay for Medical Care Expenses for you, your Spouse and eligible Dependent(s). You will be required to make this certification each Plan Year. Your failure to do so will prohibit you from enrolling in the debit card program.

In the event that a claim was reimbursed in error, you will be required to reimburse the Plan for the

improper payment. If you fail to reimburse the Plan, the Trustees may offset any future claims until the improper payment is fully recouped, and restrict or deny your access to the debit card to recoup the improper payment. If the improper payment is not recouped, the Trustees may take any action it would normally take for any other business indebtedness to recoup the improper payment.

If a claim for reimbursement under this HRA is wholly or partially denied, claims will be administered in accordance with the claims procedure set forth in paragraph (b), below.

(b) *Timing.* When you file a reimbursement claim the Claims Administrator will reimburse the you in accordance to section 5.3 of this Plan (if the Claims Administrator approves the claim), or notify you in writing that the claim has been denied (see Article # regarding procedures for claim denials and appeals procedures), within 15 days. This time period may be extended for an additional 10 days for matters beyond the control of the Claims Administrator, including in cases where a reimbursement claim is incomplete. The Claims Administrator will provide written notice of any extension, including the reasons for the extension, and will allow you 45 days in which to complete an incomplete reimbursement claim. The Claims Administrator will notify you in writing of its decision to deny the claim within 5 days after the earlier of (i) receipt of the information needed to perfect the claim or (ii) the expiration of a your 45-day period to perfect the claim.

(c) *Claims Substantiation.*

i. When seeking your benefits you may apply for eligibility by submitting an application in writing to the Claims Administrator setting forth:

(1) Your name, and
(2) Your Social Security Number, and
(3) The full name of the Covered Individual for which the Premium Expense was incurred, and
(4) Proof of purchase of insurance from the Marketplace Exchange, and
(5) and any additional documentation that the Claims Administrator may request.

ii. When seeking your benefits you may apply for reimbursement on a quarterly basis by submitting an application in writing to the Claims Administrator setting forth:

(1) Your name, and
(2) Your Social Security Number, and
(3) The full name of the Covered Individual for which the Premium Expense was incurred, and
(4) Proof of eligibility confirmation provided by the Plan Administrator at the time you applied for eligibility, and
(5) and any additional documentation that the Claims Administrator may request.

(d) *Claims Denied*. For reimbursement claims that are denied, see the appeals procedure in Article VI.

5.5 Reimbursement After Termination of Participation

When your, or your Spouse's, participation ceases under Article III, you will not be able to receive reimbursements for Medical Care Expenses incurred after your participation terminates. However, you (or your estate, or your Spouse's estate, as applicable) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to your termination of participation, provided that you (or your estate, or your Spouse's estate, as applicable) files a claim by the 60th day following the close of the Plan Year in which the Medical Care Expense was incurred. Thereafter, any Medical Care Expense will not be eligible for reimbursement.

5.6 Coordination of Benefits

Benefits under this Plan are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Medical Care Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan.

ARTICLE VI. APPEALS PROCEDURE

6.1 Procedure If Benefits Are Denied Under This Plan

If your claim for reimbursement under this Plan is wholly or partially denied, claims shall be administered in accordance with the following claims procedures. The Claims Administrator acts with respect to initial claim determinations, and the Plan Administrator acts with respect to appeals. Any claim for Benefits shall be made to the Claims Administrator.

The following timetable for claims and rules below apply:

Action	Eligibility Claim	Reimbursement Claim
Claim is submitted	Within 60 days of the close of the Plan Year	one the 1st day of the month prior to the closing of the current quarter
Notification of whether claim is accepted or denied	30 days	15 days
Extension due to matters beyond the control of the Plan	15 days	10 days
Notification of Insufficient information on the claim:	By the end of the 15 day extension period.	By the end of the 10 day extension period.
Response by Participant	45 days	45 days
Review of claim denial	15 days	5 days

The Claims Administrator will provide you with written notification of any claim denial. Written notification may also be executed by the use of electronic means. The notice will state:

(1) Information specific to identify the claim involved.
(2) The specific reason or reasons for the denial.
(3) Reference to the specific Plan provisions on which the denial was based.
(4) 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.
(5) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under section 502 of ERISA following a denial on review.
(6) 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.
(7) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. You may request reasonable access to, and copies of, all documents, records, and other information relevant to the claim. This information will be provided free of charge.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

(1) was relied upon in making the claim determination;

(2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information you submit relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

Upon receipt of a final adverse benefit determination, you have four months following receipt to request an external review of the Claim. This external review will be conducted by an independent review organization in accordance with federal guidance.

ARTICLE VII. RECORDKEEPING AND ADMINISTRATION

7.1 Named Fiduciary; Compliance With ERISA, COBRA, HIPAA, etc.

A. Named Fiduciary. The Board of Trustees, Sheet Metal Workers Local No. 112 Welfare Fund is the named fiduciary for the Plan for purposes of ERISA 402(a).

B. Laws Applicable to Group Health Plans. Benefits shall be provided in compliance with ERISA, HIPAA, and other group health plan laws to the extent required by such laws.

7.2 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

7.3 Powers of Plan Administrator

The Board of Trustees is the Plan Administrator and "named fiduciary" of the Plan. The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be

conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 7.3, the Claims Administrator shall exercise such exclusive power with respect to an appeal of a claim under Section 6.1);

(b) to prescribe procedures to be followed and the forms to be used by Participants to enroll in and submit claims pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate;

(f) to receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultations;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of account, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

7.4 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the information submitted by a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

7.5 Provision for Third-Party Plan Service Providers

The Plan Administrator may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Plan Administrator.

7.6 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

The Plan Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

(a) for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;

(b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(c) in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

7.7 Compensation of Plan Administrator

The Plan Administrator shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Plan.

7.8 Bonding

The Plan Administrator shall be bonded to the extent required by ERISA.

7.9 Inability to Locate Payee

If the Plan Administrator is unable to make payment to you because it cannot ascertain your identity or locate you, then such payment and all subsequent payments otherwise due to you shall be forfeited following a reasonable time after the date that any such payment first became due.

7.10 Effect of Mistake

If it is determined that you and/or your Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the HRA Plan. If you do not refund the overpayment or erroneous payment, the Plan Administrator reserves the right to offset any future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay.

7.11 Claim Administrator

ProFlex Administrators, LLC has been appointed to Claim Administrator by the Plan Administrator. A Claim Administrator's authority and responsibility shall be limited to that portion of the Plan that it has been authorized by the Plan Administrator to administer. The Claim Administrator shall have the authority and responsibility to:

(a) Interpret this Plan's provisions relating to coverage except where the Claim Administrator requests an interpretation, a claimant files an appeal with the Plan Administrator, or the Plan Administrator exercises its authority on its own volition. In said case, the Plan Administrator shall interpret the Plan and shall communicate in writing to the Claim Administrator the appropriate interpretation of the Plan.

(b) Administer this Plan's claim procedure.

(c) Pay benefits under the Plan by drawing checks against the claim account.

(d) Advise or otherwise assist the Plan Administrator or Employer in connection with the purchase of stop loss coverage, if any, for the benefits provided under the Plan.

(e) File claims with the insurance companies, if any, who issue stop loss insurance policies to the Employer.

(f) Perform all other responsibilities delegated to the Claim Administrator in the instrument appointing the Claim Administrator.

(g) Adhere to the HIPAA Privacy Regulation applicable to a Business Associate by

complying with the provisions of the Business Associate agreement.

7.12 Privacy Officer

The Privacy Officer has the authority and responsibility to:

(a) Ensure the compliance of all Plan Documents with the HIPAA Privacy Regulation.

(b) Establish written policies and procedures for the Plan to ensure the privacy rights of Covered individuals regarding Protected Health Information.

(c) Establish a process to handle complaints by a Participant or Covered individual, including sanctions for employees and Business Associates who fail to comply with the Plan regarding the HIPAA Privacy Regulation.

(d) Develop a Notice of Privacy Practices regarding Protected Health Information and distribute the notice to Employees Covered under the Plan.

(e) Develop a program for training employees including certification that training has been completed.

(f) Audit compliance with the HIPAA Privacy Regulation.

(g) Ensure that the Plan does not use or disclose more than the minimum necessary Protected Health Information to carry out the intended purpose.

(h) Identify the Plan's Business Associates and require a written agreement with the Plan's Business Associates that outlines their duties and responsibilities with respect to HIPAA and the Plan.

(i) Maintain records and, when required, prepare an accounting of all uses and disclosures of Protected Health Information made outside of Treatment, Payment, or Health Care Operations. The record must contain an accounting of all disclosures for up to six years from the date of the first disclosure.

(j) Allow the Covered individual access to view, copy and amend their Protected Health Information.

(k) Discipline, sanction, or terminate any person for use or disclosure of any Protected Health Information outside of Treatment, Payment or Health Care Operations.

(l) Mitigate the adverse effects of the unauthorized use of Protected Health Information.

(m) Ensure continuing compliance with 45 Code of Federal Regulations, as it may be amended from time to time.

ARTICLE VIII. HIPAA PRIVACY AND SECURITY

Introduction: Employees of the Fund have access to the individually identifiable health information of Plan participants for administration functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is Electronic PHI (see the HIPAA definitions of PHI and EPHI in Article II).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI and Electronic PHI.

The Plan Sponsor will have access to PHI and Electronic PHI from the Plan only as permitted under this section or as otherwise required or permitted by HIPAA.

8.1 Plan Sponsor Certification of Compliance

The Plan cannot disclose your Protected Health Information to the Board of Trustees unless the Trustees can certify that the Plan document incorporates the provisions of 45 CFR 164.504(f)(2)(ii), and that the Trustees agrees to conditions of disclosure set forth in this Article VIII.

8.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Trustees may request, from the Plan, information regarding your participation in the plan.

8.3 Permitted Uses and Disclosures of Summary Health Information

The Plan may disclose your Summary Health Information to the Trustees, provided that the Trustees request the Summary Health Information for the purpose of modifying, amending or terminating the Plan.

"Summary Health Information" means information (1) that summarizes the claims history, claims expenses or type of claims experienced by individuals for who a plan sponsor had provided health benefits under a Health Plan; and (2) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

8.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes

Unless otherwise permitted by law, the Plan may disclose your, your spouse's, and your dependent's, Protected Health Information to the Trustees, provided that the Trustees will use and disclose such Protected Health Information only for Plan administration purposes. "Plan administration purposes" means administrative functions performed by the Trustees on behalf of the Plan, such as quality assurance, claims processing (including appeals), auditing, and Plan monitoring. Plan administrative functions do not include functions performed by the Trustees in connection with any other benefits or benefit plan of the Fund, and they do not include any employment-related functions. Any disclosure to and use by the Trustees of your, your spouse's, and your dependent's, Protected Health Information will be subject to and consistent with the provisions of this Article IX(including, but not limited to, the restrictions on Employer's use and disclosure described in 9.5) and the specifications and requirements of the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations at 45 Code of Federal Regulations ("C.F.R.") Parts 160-64.

8.5 Restrictions on Trustees' Use and Disclosure of Protected Health Information

(a) The Trustees will neither use nor further disclose a Covered Individual's Protected Health Information, except as permitted or required by the Plan document, or as required by law.

(b) The Trustees will ensure that any agent, including any subcontractor, to which it provides a Covered Individual's Protected Health Information received from the Plan, agrees to the restrictions, conditions, and security measures of the Plan document that apply to the Trustees with respect to Protected Health Information.

(c) The Trustees will not use or disclose a Covered Individual's Protected Health Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit

plan it maintains.

(d) The Trustees will report to the Plan any use or disclosure of a Covered Individual's Protected Health Information that is inconsistent with the uses and disclosures allowed under the Plan document of which the Trustees become aware.

(e) The Trustees will make Protected Health Information available to the Plan or to the Covered Individuals who is the subject of the information accordance with 45 CFR 164.524.

(f) The Trustees will make a Covered Individual's Protected Health Information available for amendment, and will on notice amend a Covered Individual's Protected Health Information, in accordance with 45 CFR 164.526.

(g) The Trustees will track disclosures it may make of a Covered Individual's Protected Health Information that are accountable under 45 CFR 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 CFR 164.528.

(h) The Trustees will make its internal practices, books, and records relating to its use and disclosure of a Covered Individual's Protected Health Information received from the plan available to the Plan and to the US Department of Health and Human Services to determine compliance with the HIPAA Privacy Rule at 45 CFR Part 164 Subpart E.

(i) The Trustees will, if feasible, return or destroy all Protected Health Information of a Covered Individual, in whatever form or medium, received from the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Covered Individual who is the subject of the Protected Health Information, when the Covered Individual's Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all such Protected Health Information, your Employer will limit the use or disclosure of any Covered Individual's Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

(j) The Trustees will ensure that the adequate separation between Plan and Employer (i.e., the "firewall"), required in 45 CFR 504(f)(2)(iii), is satisfied.

8.6 Adequate Separation Between Trustees and the Plan

A. Only the following employees or classes of employees or other workforce members under the control of the Trustees may be given access to a Covered Individual's Protected Health Information received from the Plan or a business associate servicing the Plan:

- Privacy Official;
- Employees of the Fund; and
- Any other class of employees designated in writing by the Privacy Official.

B. The employees, classes of employees or other workforce members identified in Section 8.6(a), above, will have access to a Covered Individual's Protected Health Information only to perform the plan administration functions that Employer provides for the Plan, as specified in Section 8.5(a), above.

C. The employees, classes of employees or other workforce members identified in Section 8.6(a), above, will be subject to disciplinary action and sanctions pursuant to the Trustee's employee discipline and termination procedures, for any use or disclosure of a Covered Individual's Protected Health Information in breach or violation of or noncompliance with the provisions of this Article VIII.

8.7 Security Measures for Electronic Protected Health Information

The Trustees will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of a Covered Individual's Electronic Protected Health Information that the Trustees creates, receives, maintains, or transmits on the Plan's behalf.

8.8 Notification of Security Incident

Trustees will report to the Plan any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in its information systems, of which the Trustees become aware.

ARTICLE IX. 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:

9.1 Receive Information About Your Plan and Benefits:

This includes the ability to:

(1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report (Form 5500 Series). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

9.2 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

9.3 Enforce Your Rights:

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you

request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that 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 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 if, for example, it finds your claim is frivolous.

9.4 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 Benefits 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 publications hotline of the Employee Benefits Security Administration.

9.5 Qualified Medical Child Support Orders:

The Plan provides medical benefits in accordance with the applicable requirements of any "Qualified Medical Child Support Order" as required under ERISA. A Qualified Medical Child Support Order is any judgment, decree, or order (including approval of a property settlement agreement) issued by either a court of competent jurisdiction or through an administrative ruling that has the force and effect of state law which:

(1) Relates to the provision of child support with respect to the Child of an Employee or COBRA Beneficiary under this Plan or provides for health benefit coverage to such a Child, and is made pursuant to a state domestic relations law (including a community property law), and relates to such coverage under this Plan, or

(2) Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to this Plan, and which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a beneficiary under this Plan. For purposes of this section, an "alternate recipient" shall mean any Child of an Employee or COBRA Beneficiary who is recognized by a Qualified Medical Child Support Order as having a right to enrollment under a group health plan with respect to such an Employee or COBRA Beneficiary, and

(3) Satisfies the requirements of Section 609 of ERISA.

A procedure has been established to determine if a Qualified Medical Child Support Order exists. You may obtain a copy of the procedure at no charge from your Employer.

ARTICLE X. GENERAL PROVISIONS

10.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid from the Fund and a portion thereof may be charged to your HRA Account balance

10.2 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Trustees may amend or terminate all or any part of this Plan at any time for any reason.

10.3 Governing Law

This Plan shall be construed, administered and enforced according to the laws of the State of New York to the extent not superseded by the Code, ERISA or any other federal law.

10.4 Code and ERISA Compilation

It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

10.5 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Trustees makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from your gross income for federal, state or local income tax purposes. It is your obligation to determine whether each payment under this Plan is excludable from your gross income for federal, state and local income tax purposes, and to notify the Plan Administrator if you have any reason to believe that such payment is not excludable.

10.6 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienated by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

10.7 Headings

The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

10.8 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

10.9 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

IN WITNESS WHEREOF, this Plan document is hereby executed this ____day of _____, 2021.

SHEET METAL WORKERS LOCAL NO. 112 WELFARE FUND

Employer Trustees	Union Trustees
_____	_____
_____	_____
_____	_____
_____	_____