The Segal Group Retiree Health Plan

Summary Plan Description

Updated and Restated as of January 1, 2018

Overview

The Retiree Health Plan of the Segal Group applies to Retirees whose date of retirement is on or after January 1, 1992. The Plan offers retiree health benefits through Benefit Credits, which are based on your years of service and date of retirement, as defined in the plan. The benefits it provides are a means to acknowledge the hard work and important contributions of our employees toward the Company's success.

In this Summary Plan Description (SPD), you will find information about the benefits offered through the Plan, how those benefits are calculated, and the plan's reimbursement procedures. If you have any questions about the Plan after reading through this information, please contact the Human Resources Department in New York.

The Retiree Health Plan, along with any of the medical and dental options offered, is subject to change. This Summary Plan Description does not create a contract between the Company and any Retiree or Eligible Spouse or Dependent. In order to meet its needs under changing conditions, the Company at its discretion may, at any time, terminate or modify the Plan and the statements made in this Summary Plan Description.

Definitions

Active means a participant in the Company plan who is eligible for coverage based on active employment, and not as a COBRA Qualified Beneficiary.

Active Plan means the Company's Health Plan for coverage of Active employees and their Dependents.

Benefit Credits means credits that are provided to an Eligible Retiree by the Company to reimburse medical care costs as described in this Summary Plan Description.

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

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

Company means The Segal Group and its affiliated companies.

Dependent Child or Dependent means a child that meets the criteria for Eligible Dependent set forth in this document.

Domestic Partner means an individual who meets the Plan's criteria for a spousal equivalent and completes the appropriate documentation as required by the Plan.

Eligible Retiree means a Retiree who meets the criteria for eligibility as set forth in the Plan.

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

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

Participant means a person who is an Eligible Retiree who is participating in this Plan.

Pension Plan of the Segal Company means the Company's defined benefit pension plan under which employees may be eligible to receive either an Early Retirement Pension or a Normal Retirement Pension.

Plan means the plan as set forth in this Summary Plan Description.

Plan Administrator means the Company's Human Resources staff responsible for administration of Benefits Credits under the Plan.

Plan Sponsor means The Segal Group.

Plan Year means the 12-month period commencing January 1 and ending on December 31 of each year.

QMCSO means a qualified medical child support order, as defined in ERISA Section 609(a).

Retiree means an individual who retires from active service from the Company on or after his or her 55th birthday and has at least ten (10) years of Service with the Company, or who retires from active service from the Company on or after his or her 65th birthday and has at least five (5) Years of Service with the Company.

Spousal Equivalent means an individual who meets the criteria for Eligible Spousal Equivalent set forth in this document.

Spouse means an individual who is legally married to an Eligible Retiree as determined under applicable State law. Only Spouses who are legally married to an Eligible Retiree at the time of retirement are eligible for benefits under this Plan.

Surviving Spouse means an individual who was a Spouse and who was enrolled in this Plan on the date of the Retiree's death.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Eligibility

Once your eligibility for benefits under the Company's Active Plan ends, you, your Spouse, and your Dependents will be eligible for coverage under this Retiree Health Plan, if you meet the eligibility criteria set forth in this Summary Plan Description.

You and your Eligible Dependents are eligible for benefits under the Retiree Health Plan if you meet the following criteria:

1. You retire from active service from the Company on or after your 55th birthday, and are eligible to receive either an Early Retirement Pension or a Normal Retirement Pension from The Pension Plan of The Segal Company, and

2. You were eligible to participate in the health plan under the Segal Flexible Benefits Plan prior to your retirement from the Company.

Eligible Dependents: Your Eligible Dependents include your Spouse or Spousal Equivalent and Dependent Children who meet the following criteria:

Dependent Children: Dependent Children include the following individuals who were enrolled in this Plan on the date of retirement:

1. An Eligible Retiree's Dependent Child up to the end of the calendar month in which the child attains age 26. Dependent Children covered up to age 26 include natural born children; legally adopted children and children placed with the Eligible Retiree for adoption; stepchildren of the Eligible Retiree; and any children under the Retiree or Retiree's Spouse's legal guardianship.
2. A child under the Retiree or Retiree's Spouse's legal guardianship means an unmarried child for whom the Retiree or his or her Spouse has been named the legal guardian, provided the child is living in a parent/child relationship with the legal guardian.
3. A child that the Plan is required to cover under a Qualified Medical Child Support Order (QMCSO). A free copy of the Plan's QMCSO procedures is available from the Company.
4. An unmarried Dependent child age 26 or older who: (1) is totally and permanently disabled and unable to engage in any substantial gainful activity due to any medically determinable physical or mental impairment that can be expected to result in death or that has lasted (or can be expected to last) for a period of not less than twelve months, (2) lives with the Eligible Retiree, and (3) is a tax-dependent of the Eligible Retiree. Proof of incapacity must be provided to the Company on not less than an annual basis or upon request. The disabling condition must have been present before the child reached the age of 19.

Spouse: Spouse means an individual who is legally married to an Eligible Retiree as determined under applicable State law. Only Spouses who are legally married to an Eligible Retiree at the time of retirement are eligible for benefits under this Plan.

Spousal Equivalent: Spousal Equivalent means an individual who meets the following criteria and completes an Affidavit of Spousal Equivalency as required by the Plan:

1. Provides the dates of the spousal equivalency;
2. Are each other's sole spousal equivalent and intend to remain so indefinitely;
3. Is not married to or legally separated from anyone else;
4. Is at least eighteen (18) years of age and mentally competent to consent to contract;
5. Is not related by blood closer than that which would otherwise prohibit legal marriage in the state in which they legally reside;
6. Resides together in the same residence and intend to do so indefinitely;
7. Is committed to the Eligible Retiree's common welfare and, along with the Eligible Retiree, is responsible for basic living expenses, demonstrated by providing at least three of the following:
    a. Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
    b. Common ownership of a motor vehicle;
    c. Driver's license listing a common address;
    d. Proof of joint bank accounts or credit accounts;
    e. Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under a partner's will;
    f. Assignment of a durable property power of attorney or health care power of attorney.

Surviving Spouse: Surviving Spouse means an individual who was a Spouse and who was enrolled in this Plan on the date of the Retiree's death.

Termination of Dependent Eligibility: Your Dependents' eligibility will terminate on the earliest of the following:

1. The date your eligibility terminates;
2. On the date of your death;
3. The date your spouse and/or children no longer qualify as an eligible Dependent; or
4. The date on which the Plan is terminated or discontinued.

Retiree Health Plan

The Retiree Health Plan provides you with Benefit Credits that may be used in one of two ways.

1. Benefit Credits may be used to offset the cost of health care coverage purchased through the Company, or
2. Benefit Credits may be used solely as a Medical Expense Reimbursement Account (MERA) to reimburse you for qualified medical expenses related to your health care.

Benefit Credits are calculated and made available on an annual basis. When you retire, the Company determines the amount of Benefit Credits to which you are entitled each calendar year, and that amount will not change throughout your retirement. Benefit Credits that are not used during a calendar year are forfeited. Benefit Credits can never be paid in cash.

Benefit Credits are calculated at $100 for each full year of service, up to a maximum of 25 years or $2,500. No Benefit Credits are provided for partial years of service. Benefit Credits are not part of and cannot be combined with the Health Care Reimbursement Arrangement or any other arrangements available to Active employees.

After you retire, Benefit Credits are pro-rated for the first year of retirement if retiring other than on January 1. Benefits Credits will be applied first to the cost of individual coverage, and then to Dependent coverage.

Only Spouses, Spousal Equivalents, or Dependents covered at the time of your retirement are eligible for coverage under this Plan. If a Retiree pre-deceases an Eligible Spouse or Spousal Equivalent, the Surviving Spouse or Spousal Equivalent will continue to receive one-half of the Retiree's monthly Benefits Credits for his or her lifetime, as well as have the option to purchase a Company-sponsored health plan. If a Retiree pre-deceases Eligible Dependent Children, they are not entitled to continue to receive Benefits Credits. If a Retiree dies before a Spouse, Spousal Equivalent, or Dependents are enrolled in the Plan, the Spouse, Spousal Equivalent, or Dependents are not entitled to Benefits Credits after the Retiree's death.

At the time of retirement, you must elect to receive Benefit Credits either to offset the cost of coverage purchased through the Company or as a Medical Expense Reimbursement Account.

Benefit Credits that Offset the Cost of Health Coverage Purchased through the Company

At retirement, all of your active benefit coverage ends at the end of the month in which you terminate your employment. If you choose to receive Benefit Credits as an offset to the cost of health care coverage purchased through the Company, you may purchase medical and/or dental coverage for yourself and your Eligible Spouse and Eligible Dependents under the Company's

medical and dental plans, as described below. You must have been covered under a health plan sponsored by the Company on the day before you retired in order to choose this option.

The benefits and cost of the medical and dental plans will be determined by the Company on a year-to-year basis. If the medical or dental plans change after you retire, your coverage will reflect those changes.

Plans available to pre-65 Retirees and their families: Retirees who are under age 65 may purchase coverage for themselves and their Eligible Dependents under the Company-sponsored medical plan and/or dental plan in which they were enrolled at the time of retirement. You are responsible for paying the cost of the health plan, which will be offset by the amount of your Benefit Credits for that month. Pre-65 Retirees and their Eligible Dependents must choose the same health plan. However, if a Spouse or Spousal Equivalent is over 65, and the Retiree is pre-65, the Spouse or Spousal Equivalent may choose a Medicare Advantage plan and the Retiree may purchase coverage under the Company-sponsored health plan.

Once you or your Eligible Spouse turn age 65, the health plan will pay secondary to Medicare.

Dental Coverage: Dental coverage is only available until the last day of the month prior to the month in which you turn age 65. Your dental coverage will end at the end of the month prior to the month in which you or your Eligible Spouse turn 65. For example, if you turn age 65 on June 15, 2018, your dental coverage will end on May 31, 2018. When the Retiree turns 65, he or she cannot obtain dental coverage through COBRA. However, the Eligible Spouse or Dependent of a Retiree who turns 65 may continue dental coverage under COBRA.

Effect of COBRA Continuation Coverage: In some cases, it may be less costly for a pre-65 Retiree to choose to continue coverage under the Company's active medical plans through COBRA. If you choose to continue coverage through COBRA, you may use your Benefit Credits to offset the cost of COBRA. Then, when your COBRA continuation coverage terminates, you may use the Benefit Credits to purchase retiree health coverage offered by the Company.

Plans available to Retirees over age 65 and their families: Retirees who are over age 65 may purchase coverage for themselves and their Eligible Spouse and Eligible Dependents under a Company-sponsored health plan. For the Retiree and any Eligible Spouse over age 65, the plan will coordinate benefits with Medicare. This means, subject to federal law, the plan will pay secondary to Medicare. Payments will be made secondary to Medicare regardless of whether the Retiree or Eligible Spouse are actually enrolled in Medicare.

Retirees and their Eligible Spouses over 65 may also purchase coverage through a Medicare Advantage Plan (MAP) offered to retirees nationally. In order to purchase coverage through the MAP, you must sign up for Medicare Parts A & B through your local Social Security office, prior to purchasing the MAP through the Company. Medicare Advantage plans provide coverage through a network of providers, which may be limited based on your geographic area. The

Company may also change Medicare Advantage plans from time to time. Please contact the Human Resources – Benefits Department for a list of Medicare Advantage plans offered in your geographic area.

In general, Retirees over age 65 and their Eligible Dependents must choose the same health plan. However, Retirees over age 65 who elect a Medicare Advantage plan, and whose Eligible Spouse is under age 65, or who have Eligible Dependents under age 65 may continue coverage for the Spouse or Dependents under the Company-sponsored health plan.

Dental Coverage: Dental coverage is only available until the last day of the month prior to the month in which you turn age 65. Dental benefits for your Eligible Spouse also stop at the end of the month prior to the month in which he or she turns 65. When the Retiree turns 65, he or she cannot obtain dental coverage through COBRA. However, the Eligible Spouse or Dependent of a Retiree who turns 65 may continue dental coverage under COBRA.

High Deductible Health Plan/Health Savings Account Option: From time to time, the Company may offer a High Deductible Health Plan/Health Savings Account Option. If it does so, and a Retiree or Eligible Spouse, Surviving Spouse, or Dependent elects that plan, the Company will not make a contribution into the Health Savings Account, even if it would do so for an active employee that elects that option.

Annual Enrollment: Retirees and Eligible Surviving Spouses will be provided with the opportunity on an annual basis to participate in the Company's annual enrollment period. At that time you will receive information on the plans to be offered by the Company for the subsequent calendar year, and the premium costs. You will be able to choose from the plans during this annual enrollment process. Our annual enrollment period is typically held during the month of December or earlier if possible. During annual enrollment you can make a new election, e.g., either drop coverage and elect Benefit Credits as a Medical Expense Reimbursement Account only, or vice versa.

Payment Obligation: You must pay the premium established by the Company on a monthly basis, in the manner set forth by the Company. If you are receiving a retirement pension from the Company, the Company will deduct the coverage premium cost monthly from your check, offset by the Benefit Credits. If you are not receiving a retirement pension from the Company, each month you must send in a check made out to The Segal Group, Inc., to cover the cost of coverage. Payment is due on or before the first of the month from which you are being covered. Full details regarding payment amounts and address will be provided when you elect this option.

Benefit Credits used solely as a Medical Expense Reimbursement Account (MERA)

If you elect the Medical Expense Reimbursement Account option (MERA), you may receive reimbursement for qualified medical expenses related to your health care. If you elect the

MERA, you will not have any health care coverage through a Company-sponsored health plan. However, reimbursement of eligible but unreimbursed health care expenses can be obtained from your MERA that houses your annual allotment of Benefits Credits.

To obtain reimbursement, you must submit a Retiree MERA reimbursement form, attach supporting documentation for the qualified medical expenses, and submit the form and documentation to the Benefits Administrator at the address identified by the Company.

You may submit qualified medical expenses for reimbursement for a calendar year up until June 30 of the subsequent calendar year. For example, physician visit copayments for 2018 may be submitted for reimbursement until June 30, 2019. If you do not use your Benefit Credits within the calendar year in which they are allocated, they will be forfeited.

Qualified medical expenses eligible for reimbursement from the MERA include the following, as long as they are considered a qualified medical expense under the Internal Revenue Code:

- Copayments,
- Coinsurance,
- Deductibles,
- Prescription eyeglasses or contacts,
- Other expenses for services or treatment not covered by the group health plan in which the Retiree is enrolled,
- Premiums for Medicare Part B or D, a Medicare Supplemental Plan, or a Medicare Advantage plan, and
- If the Retiree is covered under a spouse's group health plan through the spouse's employer, the MERA may reimburse the Retiree for the cost of the dependent portion of the employee contribution, unless the contribution was made on a pre-tax basis.

Health plan premium costs, including costs for coverage under the Marketplace (Exchange) or any individual health insurance coverage, are not reimbursable under the MERA.

The MERA is similar to the Health Care Reimbursement Arrangement formerly available to Active employees but it is not the same account and the funds cannot be combined. Unused Benefit Credits for a calendar year that are not submitted by June 30 of the subsequent year will be forfeited.

Examples

Here are examples of how Benefits Credits work, based on hypothetical premium costs. These examples are for illustration purposes only, and do not represent actual costs.

1. George retires from the Company with 25 Years of Service. He and his wife are both 65 years old. George is eligible for $2,500 per year in Benefits Credits.

George elects Benefit Credits that offset the cost of health coverage purchased through the Company. George may enroll in either the Company-sponsored health plan, which coordinates with Medicare, or a Medicare Advantage plan. George elects a Medicare Advantage plan and his Benefits Credits will offset his premium cost.

2. Janice retires from the Company with 25 Years of Service. Janice is eligible for $2,500 per year in Benefits Credits. Janice's spouse is still actively employed and covers both himself and Janice under his employer's plan. Janice elects coverage under the MERA. The MERA can reimburse both medical expenses and the cost of coverage under another plan. The MERA can reimburse Janice for the dependent portion of the employee contribution paid for coverage under her spouse's plan, but only as long as that plan was paid for by her spouse on a post-tax basis.

3. Brian retires from the Company with 10 Years of Service. Brian is eligible for $1,000 per year in Benefits Credits. Brian elects Benefit Credits that offset the cost of health coverage purchased through the Company. Brian is not yet 65 years old. Brian elects coverage under the Company-sponsored health plan. Brian's Benefits Credits will offset his premium cost.

Ability to Opt-Out from receiving Benefit Credits

If you purchase coverage from the public Marketplace (Exchange) you may be eligible for a federal subsidy if you meet federal income standards. However, if you are receiving Benefit Credits, the government considers you to be enrolled in a group health plan, which disqualifies you from receiving a subsidy. Consequently, if you wish to enroll in the Marketplace (Exchange) so that you can purchase coverage and receive a federal subsidy, the Company will permit you to opt-out of your Benefit Credits for a calendar year, subject to the following requirements.

You may request the Company to allow you to opt-out of your Benefit Credits for a specific calendar year once per year, in a time and manner determined by the Company. An opt-out election must be made prior to the beginning of the plan year and is irrevocable until a reinstatement event occurs. If you opt-out of Benefit Credits for a calendar year, your Benefit Credits will be reinstated on the first day of the plan year following the year for which you opted-out, provided that you notify the Company you wish to be reinstated. Retirees, eligible Spouses and eligible Dependents may not have access to Benefit Credits after the effective date of the opt-out election and, upon reinstatement, cannot submit for reimbursement any claims incurred after the forfeiture and before the reinstatement. However, after the reinstatement event, access to the Benefit Credits is available for costs incurred after the reinstatement event.

COBRA continuation coverage

COBRA continuation coverage is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 and other members of your family when group health coverage would otherwise end. However, since this plan provides Benefits Credits, the cost of COBRA continuation coverage will be 102% of the Benefits Credits the qualified beneficiary would have received while covered under the Plan.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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." Your Spouse, and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

If you are the Spouse of a Retiree, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-Retiree dies;
- The parents become divorced or legally separated; or
- Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving Spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- Death of the employee; or
- Commencement of a proceeding in bankruptcy with respect to the employer

For all 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 the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Human Resources Department in New York.

How is COBRA continuation 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 that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

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

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the

spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about 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

The Segal Group Retiree Health Plan, Human Resources, The Segal Group, 333 West 34th Street, New York, NY 10001 (212.251.5000).

Appeals Procedure

1. If a claim for Benefits Credits is denied, the Plan Administrator shall furnish the Retiree with a written notice setting forth (in a manner calculated to be understood by the claimant):
    a. the specific reason or reasons for denial of the claim;
    b. specific reference to the Plan on which the denial is based;
    c. a description of any additional material or information necessary for the Retiree to perfect the claim and an explanation of why such material or information is necessary;
    d. a description of the Plan's review of procedures and the time limits applicable to such procedures, including a statement of the Retiree's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review;
    e. a copy of the internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, or a statement that a copy of the rule, guideline, protocol or other criterion will be provided free of charge to the Retiree upon request; and
2. A Retiree may appeal to the Plan Administrator for reconsideration of that claim. A request for reconsideration must be filed by written notice within one hundred eighty (180) days after receipt by the Retiree of the notice of denial.
3. Upon receipt of an appeal, the Plan Administrator shall promptly take action to give due consideration to the appeal. Review of a Retiree's appeal will be conducted as follows.
    a. Retiree may submit written comments, documents, records, and other information relating to the claim for benefits.
    b. Retiree shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relating to the claim for benefits.
    c. In its review, the Plan Administrator shall take into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
4. The Plan Administrator shall notify a Retiree of its determination within a reasonable period of time, but not later than 30 days after receipt of a Retiree's appeal. If the Plan Administrator denies an appeal to any extent, it will furnish the Retiree with a written notice setting forth:
    a. the specific reason or reasons for denial of the claim;
    b. specific reference to the Plan provisions on which the denial is based;

c. a statement that the Retiree is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
d. a copy of the internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, or a statement that a copy of the rule, guideline, protocol or other criterion will be provided free of charge to the Retiree upon request;
e. a statement explaining that the Retiree and the Administrator may have other voluntary alternative dispute resolution options such as mediation, and that the Retiree should contact the U.S. Department of Labor to find out what alternatives may be available.

HIPAA Privacy Rights Notice

1. Use and disclosure of Protected Health Information (PHI): The Plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations. "Payment" includes activities undertaken by the Plan determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:
    a. Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and co-payments as determined for an individual's claim),
    b. Coordination of benefits,
    c. Adjudication of health benefit claims (including appeals and other payment disputes),
    d. Subrogation of health benefit claims,
    e. Establishing, contribution rates for contributing employers, including risk adjusting amounts as necessary based on enrollee health status and demographic characteristics,
    f. Enrolling participants and dependents in the Plan (including collection of consensus card and data entry),
    g. Risk adjusting amounts due based on enrollee health status and demographic characteristics,
    h. Billing, collection activities and related health care data processing,
    i. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments,
    j. Responding to participant and beneficiary (and their authorized representatives') inquires about payments,
    k. Medical necessity reviews, or reviews of appropriateness of care or justification of charges,
    l. Utilization review, including precertification, preauthorization, concurrent review and retrospective review,
    m. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health Plan), and
    n. Reimbursement of individual overpayments to the Plan

Health Care Operations include, but are not limited to, the following activities:

a. Quality Assessment,
b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions,
c. Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,
d. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance),
e. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
f. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies,
g. Business management and general administrative activities of the entity, including, but not limited to:
h. Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification,
i. Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers,
j. Resolution of internal grievances, and
k. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.
l. Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports, and other documents.

2. The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary.
3. Notwithstanding anything in the Plan to the contrary, use or disclosure of Protected Health Information is prohibited in the following situations.
    a. Genetic Information. Use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term "underwriting purposes" includes determining eligibility or benefits, computation of premium or contribution

amounts, or the creation, renewal, or replacement of a contract of health insurance.

b. Employment-Related Actions. Use or disclosure of Protected Health Information for the purpose of employment-related actions or decisions shall not be a permitted use or disclosure.

4. For purposes of this section The Segal Group is the "Plan Sponsor." With respect to PHI, the Plan Sponsor agrees to:
    a. Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law,
    b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the 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 unless authorized by the individual,
    d. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by the individual,
    e. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
    f. Make PHI available to the individual in accordance with the access requirements of HIPAA,
    g. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
    h. Make available the information required to provide an accounting of disclosures,
    i. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the United States Department of Health and Human Services for the purposes of determining compliance by the Plan with HIPAA, and
    j. If feasible, return or destroy all PHI received from the 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. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.
    k. Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:
        a. The Senior Vice President of Human Resources
        b. The VP and Director, Employee Benefits, and staff designated by her based on their job title and function
        c. Health and Compliance staff who need group health plan data to assist in administering the Plan

d. General Counsel and her staff
e. The Chief Information Officer and staff designated by him based on their job title and function
f. Office of the President
g. Any other employee designated in writing by the VP and Director, Employee Benefits who receives PHI pertaining to the Plan for plan administration purposes.

l. The persons described in section (k) may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.
m. If the persons described in section (k) do not comply with this Plan Document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Statement of ERISA Rights

As a participant in The Segal Group Retiree Health 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 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
- 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 administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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

Enforce Your Rights

If your claim for a Benefit Credit 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 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 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, 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 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.

GENERAL PROVISIONS

Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Company may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Company's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

Governing Law

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

Code and ERISA Compliance

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.

No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of a Retiree under this Plan will be excludable from the Retiree's gross income for federal, state or local income tax purposes. It shall be the obligation of each Retiree to determine whether each payment under this Plan is excludable from the Retiree's gross income for federal, state and local income tax purposes, and to notify the Administrator if the Retiree has any reason to believe that such payment is not so excludable.

Non-Assignability of Rights

The right of any Retiree to receive any reimbursement under this Plan shall not be alienable by the Retiree by assignment or any other method and shall not be subject to claims by the Retiree'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.

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.

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.

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.

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