To: All Employees
From: Susan Sabio
Date: December 7, 2022
Subject: Important Legal & Annual Notification for 2022 Open Enrollment (covering the 2023 Coverage Year) for the health, welfare, and cafeteria programs sponsored by T.L. Cannon[1]

WELCOME TO TL CANNON'S OPEN ENROLLMENT!
(FOR THE 2023 BENEFIT/COVERAGE YEAR)

Dear colleagues,

Welcome to Annual Enrollment for the 2023 Benefit / Coverage Year!

Open Enrollment for 2023: "It's simple, we care about your wellbeing."

Here at TL Cannon, we not only care about the wellbeing of the clients, customers, and the communities we serve, we care about you. We hope this comes across in the benefits and programs we deliver to you.

This year, we have again focused on continuing to provide you with benefits to support your overall wellbeing. Please review these notices and all of your open enrollment documentation.

During this Annual Enrollment period, we encourage you to take the time to explore all the benefit options outlined in your Plan materials, our summaries of benefits and coverage, and of course, our open enrollment sessions. Please compare the plans and programs and then consider your personal healthcare needs so you can make the best possible choices for your situation. There are a variety of tools and resources offered as you make your choices because we know how important these decisions are in your overall wellbeing journey.

We are excited to be supporting you in your quest to be healthy and whole. As such, we hope the plans and programs sponsored by TL Cannon for 2023 will be instrumental in helping you achieve optimal wellbeing.

It's important that you take the time to compare the plans, review all of your options and consider your personal healthcare needs so that you can make confident choices during the enrollment period. These are important decisions for you and your family that will stay with you throughout next year.

As a friendly reminder, please do not default. If you don't enroll by December 20, 2022, your benefits will be subject to the default rules defined in this document. After Annual Enrollment, you can only make benefit changes during the year if you have a qualified change in family status. Also, if you have no coverage and want coverage – don't default because this may be your opportunity to elect coverage. In fact, we encourage you to educate yourself, ask

[1] Items are specifically listed in the Statement Regarding TLC Electronic Disclosures (as group items and/or individually as circumstances dictate).

questions, and read your open enrollment information from cover to cover. It's the very best way to review your options, compare the plans and learn how your benefits can support your (and your family's) healthcare needs. Prepare now so when Open Enrollment starts, you'll be ready to make your elections with confidence - doing what works best for you and yours.

Keep in mind that this is an offer of coverage
under the Affordable Act so please read everything carefully
and let us know if you have any questions!

Thank you for the dedication you bring to work, the perseverance you have shown through so many challenges this year, and all you do every day to make this a better place to work. It's an honor to work alongside you.

Here's to a healthy and happy you for 2023 and beyond!

Susan Sabio
Vice President of Human Resources

SPD NOTICE: You have previously been provided with a copy of your Summary Plan Description / SPD. The following document may clarify and/or modify information contained in that document. You must retain this information with your SPD. TLC/TL Cannon reserves the right at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw, or add benefits or terminate the TLC sponsored plans and programs, as well as benefits under the Plans, the SPD and its Supporting Documents, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries.

STATEMENT REGARDING TLC ELECTRONIC DISCLOSURES

Individuals entitled to receive benefits under the T.L. Cannon Corporation Group Insurance Plan and/or the T.L. Cannon Cafeteria Plan (the "Plan or "Plans") are also entitled to be furnished with certain documents required by the Employee Retirement Income Security Act ("ERISA"). T.L. Cannon ("TLC") intends to provide the following documents to you by electronic delivery (as described below).

Documents Provided by TLC **(Including any modifications to these documents)**
• Benefits Guide • Annual Notices (provided at Open Enrollment) • Program Changes • Eligibility disclosures, notices, memorandums, and communications • W-2 Information and Reporting • Reservation of Rights • Preventive Care • Patient Protections Notice • Medicare Statement • Agency Requirements and Updating Eligibility Information • Initial COBRA Notice • Mothers and Newborns Health Protection Act Notice(s) • Women's Health Cancer Rights Notice(s)

- Transparency Notice
- GINA Notice
- Michelle's Law Notice(s) / Disclosure(s)
- Claims Procedures
- Power and Authority of Insurance Companies
- Fraud
- Mammogram Coverage
- Prohibition Against Discrimination Based on a Health Factor
- Election Notice
- Statement Regarding TLC Electronic Disclosures
- Status Changes
- Disclosures About Benefit Enrollment Communications
- Open Enrollment Disclosures
- Plan, Program, and/or Coverage Option disclosures, notices, memorandums, and communications
- New York State Paid Family Leave
- Health Savings Account: General Notice
- Discrimination and Harassment Protections
- New York State Pay Equity Laws
- New York State Sexual Harassment
- Amendment and Termination Notices/Disclosures
- New York State Whistleblower Notice
- Right to Information and Circumstances That May Result in the Denial or Loss of Benefits
- Family and Medical Leave Act
- Michelle's Law
- Plan Notices
- the Summary Plan Description (SPD)
- any required Summaries of Material Modifications (SMMs)
- any summaries of Material Reduction in Covered Services or Benefits
- any required advance notice modifications
- Summary Annual Report**s**
- any SBC or Summary of Benefits and Coverage
- HIPAA Notice of Special Enrollment Rights
- Wellness Program Disclosure(s)
- Notification of Benefit Determination
- Plan Documents
- HIPAA Notice of Privacy Practices and Notice of Availability of Notice of Privacy Practices
- Health Insurance Marketplace Coverage and Your Health Coverage
- General Information Regarding Termination of Health Plan Coverage
- Other Health Care Reform Disclosures – for example, information about patient protections (rights regarding choice of primary care provider; Ob/Gyn care without referral), grandfather status; advance notice if the plan intends to rescind coverage, etc.
- Notifications Concerning Qualified Medial Child Support Notices / National Medical Support Notices
- Electronic Disclosure
- Authorization to Deduct (contributions)
- Administrator Memorandums & Communications
- Plan Sponsor Memorandums & Communications
- Administrator Memorandums & Communications
- No Contract of Employment
- Compliance with State and Federal Mandates
- Outbreak Notices

- Group Health Plan Notice (no surprise billing)
- Other Notices as Provided in the same medium/format

Electronic Delivery Method to be Used by TLC

These ERISA-required documents provided via Paychex Flex - Benetrac will be furnished to you in each case by posting on the website at http://www.paychexflex.com.

You will also be notified by mail when a new document is posted to Paychex Flex - Benetrac http://www.paychexflex.com/

Any mail notification will be provided at the last known address provided to TLC Human Resources. Please keep your address information up to date with TLC Human Resources by contacting your local Human Resources Representative.

How to Access Documents On Paychex Flex - Benetrac (http://www.paychexflex.com)

To access the documents on on Paychex Flex - Benetrac (http://www.paychexflex.com) you must have: (1) a computer with Internet access; (2) a program installed on that computer (such as Internet Explorer or Netscape) allowing you to browse the Internet, reach and log on to Paychex Flex - Benetrac http://www.paychexflex.com and; (3) the application program Adobe 8 or higher installed on your computer allowing you to open and read the documents contained on Paychex Flex - Benetrac http://www.paychexflex.com

To retain a copy of the documents provided Paychex Flex - Benetrac http://www.paychexflex.com for future reference, you must either: (a) be able to print a copy on a printer attached to the computer you are using; or (b) save a copy in electronic form onto a backup system external to your computer's hard drive (e.g., on a zip drive).

Copies of documents furnished to you electronically via Paychex Flex - Benetrac http://www.paychexflex.com will remain on Paychex Flex - Benetrac website until they become obsolete or you are contacted regarding a new location for these documents.

If any of these requirements change in a way that creates a material risk in which you will no longer be able to access and retain electronically transmitted documents, you will be furnished with notice and required to provide consent for receiving documents electronically.

What You Must Do To Receive Documents Provided Via Paychex Flex - Benetrac
http://www.paychexflex.com

To receive documents electronically, you must do the following:

1. Log on to Paychex Flex – Benetrac http://www.paychexflex.com

2. The first time you log on to Paychex Flex – Benetrac, you will need to register an account and then create your own Username and Password.

3. While logged on to Paychex Flex – Benetrac (http://www.paychexflex.com) you must complete the online Consent to receive TLC electronic disclosures by following the on-screen prompts.

You may withdraw this consent at any time by sending a written letter to please contact T.L. Cannon Corporation, Human Resources, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221 attn: Benefits Administrator/Analyst that clearly indicates that by being written in the document that it is a "Consent Withdrawn for Electronic Disclosure" and includes in the body my full name, address, and phone numbers.

Your Rights To a Paper Copy

You have a right to request and obtain a paper version of any electronically transmitted document at no charge. To do so, contact your Local Human Resources Representative or the TLC Health & Welfare Analyst, who act on behalf of the plan administrator, at the addresses listed below:

1. Local Human Resources Representative.
2. T.L. Cannon Corporation, Human Resources, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221 Attn: Benefits Administrator/Analyst, 716.634.7700 x 8118.

ADDITIONAL ANNUAL AND LEGAL NOTICES

2022 OPEN ENROLLMENT
For the 2023 Coverage/Plan Year

It is time to review options for your 2023 medical and other benefit plans!

As in past years, the 2022 Open Enrollment is your time to select the benefits that best fit your life. If you don't enroll by the deadline, the next opportunity you'll have to make changes will be during the next Open Enrollment period unless you have a qualifying life event. Open Enrollment also provides an opportunity for eligible employees and their families who do not currently have coverage, to enroll in health coverage under Plans sponsored by T.L. Cannon (if eligibility criteria are met for coverage in 2023). It also allows eligible employees who already have coverage to make changes to the various coverage options under the Plans sponsored by T.L. Cannon (assuming the employee remains eligible for coverage for 2023)

That means that this is the one time of year when benefit eligible employees can enroll in or change their medical, dental and/or vision insurance plans, other programs, and to enroll in reimbursement accounts. Outside of the annual open enrollment period, eligible employees generally cannot make changes to their health insurance elections during the year unless they have a special enrollment event or a qualifying life event (e.g., marriage, change in employment status, etc.). These are described in greater detail below. Because of this, it is very important that you take action during the open enrollment period.

For those looking to enroll, change, update, and/or modify their coverage for 2023, open enrollment is running from December 7, 2022 through and including December 20, 2022. Like last year, Human Resources will provide you with the applicable paperwork (electronically and/or hard copy, as applicable).

This is the time when those looking for health coverage (or to modify their health coverage) should conduct research and decide what healthcare plan fits best for each person (and their family, if applicable).

Please keep in mind that if you are enrolling in family coverage for the first time, for a spouse or children, required documentation may be required to be submitted to Human Resources (e.g., marriage certificate, birth certificate, supporting tax documentation, etc.) as required and allowed by applicable law(s).

DECISIONS TO MAKE DURING OPEN ENROLLMENT

Here are the initial things you will need to decide this year for your 2023 coverage.

1. Where will you get health and other benefits for 2023? Will you cover yourself and/or dependents for dental, vision, and other benefits? TLC offers various plans and programs (described in the open enrollment and plan's supporting documents).

2. Decide who you will cover. In other words, will you cover yourself and/or dependents for dental, vision, and other benefits? Please keep in mind that specific eligibility requirements must be met to cover you and your dependents and TL Cannon offers various plans and programs (described in the open enrollment and plan's supporting documents). Please note that the plan sponsor is monitoring recently released (10/2022) proposed regulations released by the Federal Department of Labor concerning classification of employees versus independent contractors and will modify Plan rules as required and applicable when final rules are released.

3. Review your choices. What are the covered benefits, deductibles, copays, co-insurance, out-of-pocket amounts, and other specifics that I would like included in my healthcare coverage. Learn about out plan and program options, along with any changes to plans, and see which benefits best fit your needs. If you need help with open enrollment, contact Human Resources. It may also help you to review your 2022 healthcare claims. Knowing how much you spent on healthcare this year can help you estimate your 2023 healthcare expenses and find the option(s) best for you. You can find your 2022 claims through BCBS and Independent Health, as applicable in the Administrative Information Section of this notice packet). You may also want to take some time and think about any additional coverage you and your family might need.

4. Use the tools we provide through TL Cannon and our vendors.

5. You should also consider if you want to save money on taxes, if possible, by taking advantage of programs offered by TLC. TLC offers certain accounts and coverages that could reduce your taxes (e.g., Health Savings Accounts, Flexible Spending Accounts, etc.) if properly elected and rules and procedures are followed. The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable). Because the money is taken out of your paycheck before taxes are calculated, you may save around 30 percent of every dollar you put in the accounts (depending on your specific circumstances). You should speak with your individual tax advisor regarding your specific circumstances.

6. Get ready to enroll. Test your log-in credentials for meetings and open enrollment. Even if you access it via a single sign-in, you may be asked to update your password and/or PIN the next time you log-in. Also, please don't be surprised if open enrollment looks a bit different this year. We've made a few changes to the look and feel to enhance your experience. You're still able to access the same resources and enrollment tools, but it may look different.

7. Enroll (or decline) coverage by December 20, 2022. Starting December 7, 2022, you will be able to gain additional information on open enrollment and enroll. Visit online enrollment **(**via http://www.paychexflex.com) to view information about enrollment and your benefits in general. The forms library is also available 24/7 throughout the year (e.g., any device with an internet connection, making it a great resource to share with your spouse or domestic partner. Review your options together and make informed decisions. Follow the instructions provided. And, when you're done, be sure to confirm your enrollment to save your choices. Print your confirmation (unless a hard copy has already been provided to you) and necessary documentation/information (unless a hard copy has already been provided to you) and keep for your records. If you need help with your benefits sponsored by TLC, please contact Human Resources who may be able to assist you with general questions about coverage options, generalized guidance about eligibility and enrollment, and help with resetting any applicable passwords.

You will have to see your own advisor to determine what programs are best for your particular circumstances. Because everyone's' circumstances are different, TL Cannon, Human Resources, etc. cannot make any decisions for you.

Follow These Steps to Complete Your Enrollment

Step 1: Log on to via http://www.paychexflex.com

Step 2: Use enrollment tools and information provided there and through the links provided (e.g., claims, Summaries of Benefits and Coverage, videos, comparisons, etc.). Consider items mentioned above in this section.

Step 3: Choose your benefits for 2023. Choose medical, dental, vision, account program, salary deferrals, disability, life insurance, etc. coverage as applicable to your eligibility and situation. If you enrolled in an option with a health savings

account, please make sure to set-up your health savings account with your vendor or through TLC's vendor KeyBank at www.key.com/hsa/ Please keep in mind that your contribution plus any applicable employer contribution (not available in all situations) cannot exceed the annual limit set by the IRS, so set your amount with care.

Step 4: Address other enrollment issues depending on your coverage/selections. For instance, enter an annual contribution amount for your flexible spending account (if applicable to you). Also, please also provide social security numbers for covered dependents if you have not already done so at our online enrollment website (http://www.paychexflex.com). Also, don't forget to update your beneficiaries, as needed. Don't forget, you only have until 12/20/2022 at 11:59 PM ET to make new choices and elections.

Step 5: Complete enrollment on or before December 20, 2022 at 11:59 PM ET. Once completed, print the enrollment confirmation page. It has your confirmation information as a reference that you can keep for your records. If you need to provide Evidence of Insurability, a message and link is provided at our online enrollment website (http://www.paychexflex.com). You may complete the form there, or request one from Human Resources. Human Resources may also provide you with a form (but is not required to do so).

Not around during open enrollment?

If you're on a leave of absence (LOA), vacation, furlough, out of the office, etc. but still eligible for benefits during the open enrollment time frame, your steps are the same. You can enroll on (http://www.paychexflex.com) from anywhere with Internet access. If you are on leave, if eligible you may also enroll on (http://www.paychexflex.com). When you come back from leave, give Human Resources a call within 30 days of your return to enroll in or make changes to other benefits. In certain situations, you may remain responsible for some and/or all premium payments during a leave of absence in accordance with applicable law(s) and guidance.

As you may have heard, insurers are now barred from discriminating against people with preexisting conditions as well as other factors like race, gender, or age. We encourage you to research your health care options thoroughly. Recently, new insurance products (e.g., short term plans and association health plans), that do not have to comply with ACA's non-discrimination rules, have proliferated. These plans can offer cheaper premiums, but may not cover many of your most basic health care needs like prescription drugs, emergency room services, maternity benefits or preventive screenings and charge higher out of pocket costs. That is why it is more important than ever for you to thoroughly research your options before you make a decision.

If you need help with your benefits sponsored by T.L. Cannon, please contact Human Resources support. Human Resources is able to assist you with general questions about coverage options, generalized guidance about eligibility and enrollment, help with resetting any applicable passwords. You will have to see your own advisor to determine what programs are best for your particular circumstances.

DISCLOSURE ABOUT BENEFIT ENROLLMENT COMMUNICATIONS

The benefit enrollment communications contain a general outline of covered benefits and do not include all the benefits, limitations, exclusions, terms, etc. of the various benefit programs provided by TL Cannon. If there are any discrepancies between the illustrations contained herein and the benefit proposals or official benefit plan documents (including any insurance documentation), the benefit proposals or official benefit plan documents (including any insurance documentation) prevail. See the official benefit plan documents for a full list of exclusions. TLC reserves the right to amend, modify or terminate any plan at any time and in any manner.

RESERVATION OF RIGHTS

As in prior years, T.L. Cannon reserves the right at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add benefits or terminate the T.L. Cannon plans and programs, as well as benefits under the Plans, the SPD and its Supporting Documents, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. To be clear, this is an express and unambiguous grant to Plan decision makers and their delegates discretionary authority to the greatest extent allowable by law. Also, to the extent required by the Employee Retirement Income Security Act (ERISA), if there is a material reduction in covered services or benefits under the Plan, the reduction will be disclosed to you no later than 60 days after the date on which the reduction is adopted.

T.L. Cannon also reserves the right to cancel coverage due to non-payment of premiums as allowed by applicable law(s) and regulation(s). The Plan's terms cannot be modified by written or oral statements to you from Human Resources representatives or other personnel. In the event of any discrepancy between the plan documents and this document or written or oral statements, the plan documents will govern.

STATUS CHANGES

Changing Your Pre-Tax Contribution Amount Mid-Benefit/Coverage Year

As in prior years, TLC continues to sponsor a program that allows you to pay for certain benefits using pre-tax dollars. This means that under this program, contributions are deducted from your paycheck before federal, state and Social Security taxes are withheld. As a result, you may be able to reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation.

As a trade-off, the rules require that the benefits you choose during Open Enrollment are for all of 2023 unless you have a qualified status change in 2023, such as marriage, the birth of a child, or your spouse loses or gets medical coverage, etc. The actual events that will allow for a change in status are described in greater detail in the Benefits Guide provided to you an open enrollment and you plan documentation. If you have a qualified status change, you may be able to update some of your enrollment choices within the mandated time frames to make that change.

Please keep in mind that if you are enrolling in family coverage for the first time, for a spouse or children, required documentation may be required to be submitted to Human Resources (e.g., marriage certificate, birth certificate, supporting tax documentation, etc.) as required and allowed by applicable law(s).

******Please note: Not all changes will apply to all benefits provided. Further, this is only a summary and several exceptions apply and various requirements must be met (contained in the Plan documentation). Any and all changes in status are in the sole discretion of the Plan Administrator. ******

Given the uncertainty of the current times, laws and/or regulations may change throughout the year. In such situations, the Plan will be interpreted based on guidance released and the Plan Administrator will interpret provisions as necessary, on a uniform and nondiscriminatory basis, for the operations of the Plan.

IRS Consistency Rules May Also Apply: Generally, the change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. If your spouse's employment terminates and he/she loses employer-sponsored coverage, you may be able to elect coverage for yourself and your spouse under our program. However, many events do not necessary affect eligibility for coverage per se.

Please review all applicable TLC Plan and program documentation for details on when each particular program allows you to elect or cancel coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ and/or provide different rules and/or standards. You may also contact the Status Change Contact Person listed below in this notice.

Prospective Election Changes: Election changes must be made using the appropriate status change request form, which is a salary reduction agreement (which may be provided electronically). Both funding and coverage for a qualifying status change must be on a prospective basis except for the retroactive enrollment that applies in the case of an election made within 30 calendar days of a birth, adoption or place for adoption.

All status changes except for birth, adoption and placement of adoption must be executed prospectively. For example, in the case of a marriage, spousal coverage would be effective only after the date of the status change event, if the request is made within 30 calendar days of the event and after a status change form is completed. The start date of coverage for a prospective status change will be the first day in the effective pay period, which may or may not be the actual date of the status change event.

Given recent events related to COVID19 and the uncertainty of the current times, laws and/or regulations may change throughout the year. In such situations, the Plan will be interpreted based on guidance released and the Plan Administrator will interpret provisions as necessary, on a uniform and nondiscriminatory basis, for the operations of the Plan.

Cessation of Required Contributions: TLC can terminate coverage if an employee fails to make the required premium payments for the benefits elected and the employee may not make new elections for the remainder of the benefit/coverage year.

Plan Coverage Changes: An employee may also be able change to a similar health plan if a third-party provider of health benefits significantly curtails or stops providing health coverage during the plan year. This may not apply to health savings account benefits. Please contact Human Resources.

Unforeseen Environment Changes: Given recent events, please keep in mind that these laws and/or applicable guidance may change rapidly throughout the year. This is especially true in the uncertain times we have recently encountered. In such situations, the Plan will be interpreted based on guidance released and the Plan Administrator will interpret provisions as necessary, on a uniform and nondiscriminatory basis, for the operations of the Plan. For example, IRS Notice 2020-29, found at https://www.irs.gov/pub/irs-drop/n-20-29.pdf, allows for group health plans to be amended to allow for certain mid-year elections that would otherwise not be permitted under the current mid-year election rules. Generally, cafeteria plan elections are irrevocable, and changes can only be made based in limited circumstances and if allowed in the cafeteria plan documents. Under the relief provisions, cafeteria plans can be amended to allow for certain prospective mid-year changes with respect to certain elections. A cafeteria plan may choose to implement the relief provided under Notice 2020-29 but is not required to do so. Moreover, an employer can determine the extent to which such relief is made available, including limiting the time period during which such changes can be made. However, the employer will need to consider any nondiscrimination considerations as well as the potential for adverse selection of health coverage. Notice 2020-29 breaks the relief up into four main areas: 1) employer-sponsored health coverage; 2) health-care flexible spending account (FSA) elections; 3) dependent-care FSA elections; and (4) health savings accounts.

YOU MUST CONTACT HUMAN RESOURCES / BENEFITS OFFICE WITHIN 30 CALENDAR DAYS OF A STATUS CHANGE. THE ACTUAL START DATE OF COVERAGE WILL DEPEND ON THE STATUS CHANGE AND IF IT IS ELIGIBLE FOR A RETROACTIVE ELECTION. IF POSSIBLE, CONTACT THE STATUS CHANGE CONTACT PERSON (LISTED DIRECTLY BELOW) PRIOR TO AN ANTICIPATED STATUS CHANGE SO WE CAN ATTEMPT TO WORK WITH YOU TO DETERMINE THE EFFECTIVE DATE OF COVERAGE.

Please keep in mind that if you are enrolling in family coverage for the first time, for a spouse or children, required documentation may be required to be submitted to Human Resources (e.g., marriage certificate, birth certificate, supporting tax documentation, etc.) as required and allowed by applicable law(s).

STATUS CHANGE CONTACT PERSON: Via Writing - Plan Administrator at T.L. Cannon Corporation, Attention Human Resources, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221

Via Telephone: Benefits Administrator/Analyst, 716.634.7700 x8118.

Midyear Change to Part-Time Status; Reduced Hours; & Exchange Enrollment

Separate notices will provide special enrollment rights for specific situations due to enrollment in a Qualified Health Plan. These situations are limited to circumstances where:

1. The employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

2. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Special rules also apply for a Midyear Change to Part-Time Status and Reduced Hours. A separate notice was provided describing such events, program operations for such events, and the requirements necessary for such events. Also, due to COVID19, the Plan has allowed for certain other changes as allowed by regulatory agencies and applicable guidance. If you believe this applies to you, please contact the Status Change Contact Person listed above.

Given recent events related to COVID19 and the uncertainty of the current times, laws and/or regulations may change throughout the year. In such situations, the Plan will be interpreted based on guidance released and the Plan Administrator will interpret provisions as necessary, on a uniform and nondiscriminatory basis, for the operations of the Plan.

For additional copies and/or more information, call T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 80 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

You may also learn about Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment rights that allow you to enroll in coverage outside open enrollment in certain situations, if you qualify. More information on additional HIPAA special enrollment rights is provided below at the section entitled HIPAA Notice of Special Enrollment Rights.

PROGRAM STRUCTURE STATEMENT

All Program structure determinations are made at the sole discretion of the Plan Administrator. TLC's plans and programs contain insured and self-insured components. When a benefit is self-insured, it means that TLC pays benefit claims rather than an insurance company.

Self-insured. When a plan or plan option is self-insured, it means the sponsor (in this case, TLC) assumes the financial risk of the claims incurred by participants/employees and eligible dependents. This can be wholly or partly depending on plan structure. Claims are paid from sponsor and participant contributions (premiums). A plan sponsor may also hire an administrator to process claims, manage provider networks and handle other administrative tasks.

What about insured benefits offered by TLC? When a plan or plan option is fully insured, the sponsor pays premiums (consisting of both sponsor and participant contributions) to an insurance carrier, which assumes the financial risk of paying for claims, as well as the responsibility for all of the administrative duties listed above.

Using both insured and self-insured program benefits gives TLC the flexibility to create customized plan designs and benefits for our eligible employees and their eligible dependents and to help manage plan costs. Please keep in mind that self-insured health plans are not subject to state insurance laws, which typically govern fully insured health plans. State insurance laws may require fully insured plans to provide benefits that may not be offered under the self-insured health plans (or benefit components of larger plans). For more information, contact the Human Resources Department.

GRANDFATHERING STATUS – NOTICE

Grandfathered health plans under the Affordable Care Act (ACA) are those existing without major changes to their provisions since March 23, 2010, the date of the ACA's enactment. Employers were required to monitor and determine their plan designs/structures to determine the grandfather status of each plan/program. TLC has continually done this. There were no structural changes for the 2023 benefit/coverage year. Accordingly, TLC has determined that all plans/programs/coverage options sponsored by TLC (TLC or Employer) have lost grandfather status under ACA. With the exception of a transition period in 2010, a plan that loses grandfathered status, even inadvertently, cannot get it back. This statement only applies to those benefits subject to such Affordable Care Act requirements and to which such rules apply.

Upon losing grandfathered status, the plan was required to comply with all of the requirements that apply to non-grandfathered plans as of the effective date of the change that caused the loss of status. Because of this loss of grandfather status, the applicable plans/programs/coverage options under the Plan have met required Affordable Care Act consumer protection and other requirements as a non-grandfathered plan since January 1, 2014 (e.g., certain preventive services without cost-sharing, etc.). As in prior years, the Plan reserves all of its rights to amend and terminate such benefits (and including but not limited to any associated eligibility requirements) in accordance with all applicable laws and requirements applicable to such arrangements.

.

Questions concerning this statement and/or the grandfathering status of the T.L. Cannon programs may be directed to T.L. Cannon Corporation, Human Resources, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221 Attn: Benefits Administrator/Analyst 716.634.7700 x8118. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebxa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

TLC IS PROVIDING YOU WITH AN ACA OFFER OF COVERAGE
****** You Need to Elect Coverage to have Coverage ******

2023 Default Rule for All Coverage
If You Fail to Make an Election: <u>No Coverage</u>

During the 2022 open enrollment period (running December 7, 2022 through and including December 20, 2022) you are being provided with an **<u>offer of coverage</u>** for the 2023 Plan Year/calendar year. If you want to have medical, dental, vision, life insurance, accidental death and dismemberment, short-term disability, long-term disability, and cafeteria plan coverage (salary reduction on pre-tax basis, health FSA coverage, and certain HSA contributions) under the Plan, you are required to make an election during open enrollment.

If you do **not** make an election for coverage during the open enrollment period, then you will **not** be provided with coverage throughout the 2023 plan year (unless you have an appropriately documented and requested special change in status or special enrollment event that allows for a mid-year election). This means that if you do not make an election for coverage during the 2022 open enrollment period, your old 2022 election for plan coverage (medical, dental, vision, life insurance, accidental death and dismemberment, short-term disability, long-term disability, and cafeteria plan coverage – (salary reduction, health FSA and certain health HSA contributions) will terminate on December 31, 2022 and you (and, if applicable, your spouse and dependents) will have **no coverage** for all of 2023 (unless certain limited exceptions specifically apply to you such as a change in status, special enrollment, etc.). Obviously, this does not apply to any legally mandated benefits.

Your 2023 election (or no coverage if you fail to make an election) will be effective as of January 1, 2023 and last for the entire 2023 Plan Year/coverage year (unless a different result is required by applicable plan rules, e.g., certain limited changes in status, special enrollment rights, the Plan is amended prospectively, etc.). Any contributions for coverage will be deducted from your paycheck on a pre-tax basis under the Cafeteria Plan sponsored by T.L. Cannon upon completion of the required salary reduction forms and requirements as dictated by applicable Plan and/or program documentation. You must complete any applications, forms, or statements that plan representatives request in the normal course or as specified and the Plan will rely on the information you provide.

This means that you are being provided with an offer of coverage for the 2023 Plan Year/coverage year during the 2022 open enrollment period (running from December 7, 2022 through and including December 20, 2022).

If applicable, you will also have to properly establish (or modify) your health savings account (as applicable per operations and participant elections).

This also means that if you elect coverage for the 2023 Plan Year/coverage year, you will be required to pay any applicable premium(s) for the 2023 Plan Year/coverage year at the 2023 rates (which may be higher than the 2022 rates for similar cover and/or coverage tiers).

This applies to your coverage and, if applicable, your spouse and dependents coverage (unless a different result is required by applicable Plan rules).

This is important because if you do nothing, (meaning you do not properly make an election by December 20, 2022), it could result in: (1) you and/or one of your dependents (spouse/child) not being covered by the Plan for all or part of the 2023 Plan Year/coverage year, (2) you (and/or your dependents/spouse/child) being forced into an option and/or coverage tier even though you wanted a different option, and it could also (3) amount to a rejection of an "offer of coverage" for you and/or your dependent (spouse/child) in a plan that is both affordable and provides minimum value.

Because of this, if you want a specific medical, dental, vision, life insurance, accidental death and dismemberment, short-term disability, long-term disability, and/or cafeteria plan coverage (salary reduction on pre-tax basis, health FSA coverage, and certain HSA contributions), you must make a formal election by enrolling in coverage on the forms/processes provided to you by Human Resources Department. You must complete any applications, forms, or statements that plan representatives request in the normal course or as specified and the Plan will rely on the information you provide.

This also means that if you want a specific medical coverage option or tier (or no coverage under the Plan), you must make a formal election by enrolling or waiving coverage on Benetrac or contact the Human Resources Department for assistance.

KEY THINGS TO KNOW ABOUT THE AFFORDABLE CARE ACT

As passed, the ACA's individual mandate requires that nearly everyone have medical coverage or pay a penalty. Various actions have been taken by administrations since passage so you should contact your tax advisor on status and specifics as to how this applies to you.

TLC strives to remain in compliance with these requirements, to offer the level of coverage to satisfy the individual mandate, and offer affordable coverage with at least the minimum benefit value (called "minimum essential coverage") required under the ACA. Anyone can shop in the public health insurance marketplace. While some low-income individuals qualify for subsidized coverage, TLC employees generally may not qualify because of the cost and benefit value of our health plans. For more information about the ACA, visit www.healthcare.gov.

QUALIFIED MEDICAL CHILD SUPPORT & NATIONAL MEDICAL SUPPORT NOTICES

Under current law/guidance, TLC sponsored group health plans are required to extend health care coverage to certain children of a parent-employee who is divorced, separated, or never married when ordered to do so by a Court and/or state authorities. These can come in two forms: (1) Qualified Medical Child Support Order (QMCSO) or (2) a National Medical Support Notice (NMSN). Both of these are described in greater detail below.

In accordance with Section 609(a) of ERISA, the Plan will provide health coverage to a child of an eligible employee in the accordance with the terms of any medical child support order that the Plan Administrator determines to be a "qualified medical child support order." A qualified medical child support order is a judgment, decree, or order issued by a court that provides for child support or health benefit coverage relating to benefits under the Plan or a national medical support notice that in either case meets certain requirements regarding substance and form. You must submit medical child support orders and national medical support notices to the Plan Administrator. The Plan Administrator will notify the involved individuals of its receipt of the order or notice and of the Plan's procedure for determining whether it is a qualified order. You may request a copy of the Plan's procedure for determining whether an order or notice is a qualified medical child support order from the Plan Administrator. Any requirements and interpretations concerning the custodial or non-custodial requirements shall be determined by the Administrator in its sole discretion.

As provided, the Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries may obtain without charge, a copy of such procedures from the Administrator.

The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable). Some of these procedures are included below.

Except as otherwise expressly provided in the Plan or program (of in the benefit plan's supporting documents), the Plan administrator's powers shall include, but shall not be limited to the ability to take all actions necessary or appropriate to determine and communicate whether judgments, decrees or orders issued by courts of competent jurisdiction or state administrative agencies the findings of which have the force and effect of law qualify as QMCSOs, including, but not limited to, establishing and maintaining operational procedures, and administering any QMCSO.

1. What is a QMCSO and who decides whether the order is "qualified"?

A QMCSO is a judgment, decree, or order, issued by a court or through a state administrative process, that requires group health plan coverage for the child of a plan participant (called an "alternate recipient"), and meets certain legal requirements. Such orders typically are issued as part of a divorce or as part of a state child support order proceeding.

The Plan Administrator for the applicable plan determines whether a medical child support order

(including NMSN's) meets the requirements for treatment as a QMCSO. The Plan Administrator has designated certain individuals within the Human Resources Department to receive all medical child support orders and NMSN's delivered to the plan/programs and to follow these procedures.

2. What is a National Medical Support Notice ("NMSN")?
Certain state child support enforcement agencies are required by federal law to use the National Medical Support Notice when enforcing the provision of health care coverage to children under an employment related group health plan. When properly completed, the NMSN will constitute a QMCSO.

3. What procedures are followed upon receipt of a medical child support order or NMSN?
The Plan Administrator or designee will promptly notify the plan participant and each alternate recipient (at the address specified in the order), and any legal representatives, of the receipt of the order/Notice and provide a copy of these QMCSO procedures.

The Plan Administrator or designee will review the order to determine if it meets the legal requirements of a QMCSO.

Within 40 business days after receipt of the order or Notice, or sooner if reasonable, the Plan Administrator or designee will notify the plan participant and alternate recipient (and any legal representatives) that either: (a) the order is a QMSCO; or (b) the order is not a QMCSO, along with an explanation of the defective or missing provisions. For NMSN's, the state agency and any other parties indicated in the Notice will also be notified, using the spaces indicated on the Notice. For NMSN's, the Plan Administrator or designee will complete and follow the instructions provided under the terms of the Plan and any applicable polices/procedures.

If the order or NMSN is determined to be a QMCSO, additional information will be provided, such as the effective date of the child's coverage, the steps necessary to effectuate coverage, a description of the coverage, and any forms or documents necessary for plan enrollment.

4. What are the procedures for determining whether medical child support orders and NMSN's are QMCSO's?
The Plan Administrator or designee will review medical child support orders and NMSN's to determine whether the order or Notice:
-Is a judgment, decree, or order (including approval of a settlement agreement) which provides for child support with respect to a child of a group health plan participant 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 benefits under such plan, or is made pursuant to a law relating to medical child support described in section 1908 of the Social Security Act with respect to a group health plan.

-Creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan.

-Specifies the name and last known mailing address of the plan participant and the name and mailing address of each alternate recipient (the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any alternate recipient).

-Includes a reasonable description of the type of coverage to be provided by the plan to each alternate recipient, and the period to which such order applies.

-Does not require the plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act.

5. What are the procedures for administering the provision of benefits under QMSCO's?

-Each alternate recipient under a QMCSO will be treated as a beneficiary under the plan for all purposes of ERISA, specifically including ERISA's reporting and disclosure requirements (i.e., receipt of summary plan descriptions and summaries of material modifications).

-The alternate recipient will be added (or will remain) as a dependent of the plan participant for purposes of member contributions and deductibles.

-Payment for benefits made by a group health plan pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian or to an official of a State or political subdivision thereof whose names and address have been substituted for the address of an alternate recipient in a QMCSO.

6. Designation of Representative

Alternate recipients may designate a representative for receipt of copies of notices that are sent to the alternate recipient.

COMPLIANCE WITH STATE AND FEDERAL MANDATES

To the extent applicable, the Plan will provide coverage and benefits in accordance with the requirements of all applicable laws, including the ACA, USERRA, COBRA, HIPAA, NMHPA, WHCRA, FMLA, MHPA, MHPAEA, HITECH, Michelle's Law, No Surprise Billing, and GINA, as well as coverage and benefit mandates relating to COVID19 emergency (as applicable as determined by the Administrator's sole discretion). Such requirements may be discussed in other areas of these notices and other plan documentation. Contact Human Resources if you have any questions or concerns about these requirements.

TRANSPARENCY NOTICE

The Transparency in Coverage final rule was released the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (DOTr). This rule was put in place to disclose health care price information in the hands of consumers and other stakeholders, so that consumers are empowered with the critical information they need to make informed health care decisions.

The requirements in this rule provide consumers with tools to access pricing information through their health plans. The Transparency Rules will require most group health plans, and health insurance issuers in the group and individual market to disclose price and cost-sharing information to participants, beneficiaries, and enrollees.

The Transparency in Coverage Final Rules require group health plans to offer self-service price comparison tools (by internet website, in paper form upon request, or by telephone), with respect to an initial list of 500 items and services identified by government agencies beginning on or after January 1, 2023. For plan years beginning on or after January 1, 2024, all items and services must be available through the self-service tools. If you would like to see a list of the 500 items discussed above, it is available at: https://www.cms.gov/healthplan-price-transparency/resources/500-items-services).

These price comparison tools require plans to disclose estimated cost-sharing information through an online tool, and in paper form upon request. Disclosure of cost-sharing information is intended to allow participants to review or request covered items or services by billing code or descriptive term, identifying in-network providers or out-of-network allowed amount for covered items or services, according to the participant's plan design and should include certain member-level details.

We have contracted with insurers/vendors to integrate an interactive online price comparison tool with member-level benefits and details. These vendors have told us that this solution will comply with applicable privacy and security measures and have the 500 shoppable services available for you in 2023. By 2024 it is anticipated that the remaining items and services will be added to the portal and paper forms will be available upon request (with the vendors' customer service team(s) available and able to assist via phone).

We hope you see this as an opportunity to increase your engagement in their health care and pharmacy benefits provided under the Plan.

SUMMARIES OF BENEFITS AND COVERAGE (SBC)

The Affordable Care Act (or healthcare reform law) requires that you receive a Summary of Benefits and Coverage (SBC). The SBC is a standardized comparison document The purpose of the SBC is to help you understand and evaluate your health plan choices. SBCs for each of the TLC medical plan options explained to you during enrollment (annual or otherwise).

SBCs for each of the T.L. Cannon sponsored medical plan options have been made available to you. Additional paper versions of this notice, as well as the SBCs, are available up request, free of charge, by contacting T.L. Cannon Corporation, Human Resources, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, Attn: Benefits Administrator/Analyst, 716.634.7700 x8118.

The SBCs are intended to improve information so you can better understand your coverage. Generally, it consists of: (1) A short, plain-language Summary of Benefits and Coverage (SBC) and (2) A Uniform Glossary of terms used in health coverage and medical care. This information is intended to provide you with an "apples-to-apples" comparison when you're looking at plans. The SBC also includes details, called coverage examples, which show you what the plan would cover in 2 common medical situations: diabetes care and childbirth. The goal of the SBC is to help you understand and evaluate your health plan choices. The government has provided a general format for such documents and we are providing them to you as provided by our vendors . Even though these are prepared by our vendors, please note that the Plan Administrator follows policies and procedures to act prudently in monitoring our service providers with regard to the SBCs (reviewing drafts before they are distributed, monitoring distribution, etc.). If you have not received an SBC and/or if you have any questions or concerns, please contact Human Resources.

HEALTH FSA LIMITATIONS

Under the current terms of the cafeteria plan sponsored by TLC, you are able to make certain salary reduction contributions to a health flexible spending account that is offered under the cafeteria plan (if you are eligible for such coverage and all applicable rules and requirements are met). Although TLC is allowed to impose its own dollar limit on employee's salary reduction contributions to a health FSA (that is equal to or lower than applicable legal requirements), TLC has chosen to allow employees to defer a specific amount into their health FSA for the 2023 program year as provided in the open enrollment materials. Please note that depending on options elected by the employee, the FSA benefit may be limited by other rules that dictate types of benefits that could be elected (e.g., FSAs compatible with health savings accounts, etc.).

THE GENETIC INFORMATION NONDISCRIMINATION ACT NOTICE

GINA expands the genetic information nondiscrimination protections included in Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under GINA, group health plans cannot base premiums for a plan or a group of similarly situated individuals on genetic information. GINA generally prohibits plans from requesting or requiring an individual to undergo genetic tests, and prohibits a plan from collecting genetic information (including family medical history) prior to or in connection with enrollment, or for underwriting purposes. GINA applies generally to group health plans. Unlike the provisions under Title I of HIPAA, there is no exception for very small health plans with less than two participants who are current employees.

Before the Affordable Care Act, HIPAA prevented a plan or issuer from imposing a preexisting condition exclusion based solely on genetic information. Under the Affordable Care Act, plans are prohibited from excluding coverage or benefits due to any preexisting condition. HIPAA continues to prohibit discrimination in individual eligibility, benefits, or premiums based on any health factor (including genetic information). GINA provides additional underwriting protections, prohibits requesting or requiring genetic testing, and restricts the collection of genetic information. Specifically:

• GINA provides that group health plans cannot adjust premiums or contribution amounts
for a plan, or any group of similarly situated individuals under the plan, based on genetic information of one or more individuals in the group. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.)

• GINA generally prohibits plans from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. A plan or issuer may request the results of a genetic test to determine payment of a claim for benefits, but only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer under certain conditions to request (but not require) that a participant or beneficiary undergo a genetic test.

• GINA prohibits a plan from collecting genetic information (including family medical history) from an individual prior to or in connection with their enrollment in the plan, or at any time for underwriting purposes. Under GINA, underwriting purposes includes rules for determination of eligibility for benefits and the computation of premium and contribution amounts. Thus, under GINA, plans are generally prohibited from offering rewards in return for the provision of genetic information, including family medical history information collected as part of a Health Risk Assessment (HRA). GINA includes an exception for incidental collection of genetic information, provided the information is not used for underwriting purposes. However, the regulations make clear that the incidental collection exception is not available if it is reasonable for the plan or issuer to anticipate that health information will be received in response to a collection, unless the collection explicitly states that genetic information should not be provided.

What is Genetic Information?

Genetic information means information about an individual's genetic tests, the genetic tests of family members of the individual, the manifestation of a disease or disorder in family members of the individual or any request for or receipt of genetic services, or participation in clinical research that includes genetic services by the individual or a family member of the individual. The term genetic
information includes, with respect to a pregnant woman (or a family member of a pregnant woman) genetic information about the fetus and with respect to an individual using assisted reproductive technology, genetic information about the embryo. Genetic information does not include information about the sex or age of any individual.

Genetic information includes information about an individual's genetic services and tests. What do these include?

Genetic services mean genetic tests, genetic counseling, or genetic education. Genetic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. A genetic test does not include an analysis of proteins or metabolites directly related to a manifested disease, disorder, or pathological condition.

Therefore, some examples of genetic tests are tests to determine whether an individual has a BRCA1, BRCA2, or colorectal cancer genetic variant. In contrast, an HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test.

Genetic information includes an individual's genetic tests and information about the manifestation of a disease or disorder in an individual's family member. A genetic test does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition.

So, what is a manifested disease?

A manifested disease is a disease, disorder, or pathological condition for which an individual has been or could reasonably be diagnosed by a health care professional (with appropriate training and expertise in the field of medicine involved). A disease is not manifested if a diagnosis is based principally on genetic information. For example, an individual whose genetic tests indicate a genetic variant associated with colorectal cancer and another that indicates an increased risk of developing cancer, but who has no signs or symptoms of disease and has not and could not reasonably be diagnosed with a disease does not have a manifested disease.

While plans are prohibited from adjusting group premiums or contributions based on genetic information, plans can increase the premium or contribution based on the manifested disease or disorder of an individual enrolled in the plan. This is because information about an individual's manifested disease or disorder is not genetic information with respect to that individual.

GINA prohibits a group health plan from adjusting group premium or contribution amounts for a group of similarly situated individuals based on the genetic information of members of the group. This is a change from HIPAA's prior nondiscrimination requirements, which allowed plans to adjust premiums or contributions for the group health plan or group of similarly situated individuals (but not for specific individuals within the group) based on genetic information, as well as other health factors.

Therefore, even if a plan obtained individual genetic information about group members before GINA's effective date, it cannot be used to adjust the group premium.

Under GINA and HIPAA, a plan can charge a higher overall, blended per-participant amount based on the manifestation of a disease or a disorder of an individual enrolled in the plan. However, a plan cannot use the manifestation of a disease or disorder in one individual as genetic information about other group members to further increase the group premium. A plan can take into account the costs associated with providing benefits for covered genetic tests or genetic services in determining overall premium or contribution amounts. Note, under HIPAA, a plan cannot charge an individual more for coverage than other similarly situated individuals in the group based on any health factor, including a manifested disease or disorder.

A health plan is generally (and only in certain circumstances) able to obtain the results of a genetic test to make a determination regarding payment of a claim for benefits under the plan. More specifically, if a plan conditions payment

for an item or service based on medical appropriateness and the medical appropriateness depends on the genetic makeup of the patient, then the plan is permitted to condition payment for the item or service on the outcome of a genetic test. The plan may also refuse payment in that situation if the patient does not undergo the genetic test. The plan may request only the minimum amount of information necessary to make a determination regarding payment.

What about health risk assessments / HRAs?

GINA prohibits a plan from collecting genetic information (including family medical history) prior to or in connection with enrollment. Thus, under GINA, plans must ensure that any HRA conducted prior to or in connection with enrollment does not collect genetic information, including family medical history.
Under GINA, there is an exception for genetic information that is obtained incidental to the collection of other information, if 1) the genetic information that is obtained is not used for underwriting purposes and 2) if it is reasonable to anticipate that the collection will result in the plan receiving health information, the plan explicitly notifies the person providing the information that genetic information should not be provided. Therefore, a plan conducting an HRA prior to or in connection with enrollment, should ensure that the HRA explicitly states that genetic information should not be provided.

GINA prohibits a plan from collecting genetic information (including family medical history):
a) prior to or in connection with enrollment; or b) at any time for underwriting purposes.

Because completing the HRA results in a reward, the request is for underwriting purposes and is prohibited. A plan may use an HRA that requests family medical history, if it is requested to be completed after and unrelated to enrollment and if there is no premium reduction or any other reward for completing the HRA.

A plan may offer a premium discount or other reward for completion of an HRA that does not request family medical history or other genetic information, such as information about any genetic tests the individual has undergone.

The plan should ensure that the HRA explicitly states that genetic information should not be provided. This is because GINA provides an exception for genetic information that is obtained incidental to the collection of other information, if 1) the genetic information that is obtained is not used for underwriting purposes and 2) if in connection with any collection it is reasonable to anticipate that health information will be received, the collection explicitly states that genetic information should not be provided.

Plans may use two separate HRAs; one that collects genetic information, such as family medical history, which is conducted after and unrelated to enrollment and is not tied to a reward, and another HRA that does not request genetic information, which can be tied to a reward. In addition, under GINA group health plans may also reward:

- Participation in an annual physical examination with a physician (or other health care professional) who is providing health care services to the individual, even if the physician may ask for family medical history as part of the examination;
- More favorable cost-sharing for preventive services, including genetic screening; and
- Participation in certain disease management or prevention programs.

The incentives to participate in such programs must also be available to individuals who qualify for the program but have not volunteered family medical history information through an HRA.

EXPLANATION OF BENEFITS/ EOB

An Explanation of benefits / EOB generally summarizes claims activity by identifying health care providers, showing charges from the health care providers, and generally provides an estimate of amounts you may owe. If you have any

questions about this form and/or the EOB in general, please contact your insurer (see address and contact information below) or T.L. Cannon Corporation, Human Resources, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221 Attn: Benefits Administrator/Analyst, 716.634.7700 x8118.

PRINT TEMPORARY MEDICAL ID CARDS

If you already have coverage, you should already have a medical ID card. A new card may be sent to you in the mail. If you're a new member, you can expect both cards in the mail (as applicable). Be sure to have your medical and prescription drug ID cards handy when visiting your doctor's office and/or pharmacy. If you've lost your ID card or are waiting to receive your new card(s), please contact your insurer (see address and contact information below) or T.L. Cannon Corporation, Human Resources, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221 Attn: Benefits Administrator/Analyst, 716.634.7700 x8118.

MICHELLE'S LAW NOTICE
Continued Coverage for Dependents Students
on Medically Necessary Leave of Absence

Note: Under the Affordable Care Act, group health plans and issuers are generally required to provide dependent coverage to age 26 regardless of student status of the dependent. Nonetheless, under some circumstances, such as a plan that provides dependent coverage beyond age 26, Michelle's Law provisions may apply.

This notice is and provided only to the extent applicable after applying the mandates contained in the Affordable Care Act, as amended (also generally known as Health Care Reform). Michelle's Law provides continued coverage under group health plans for dependent children who are covered under a T.L. Cannon group health plan as a student, but lose their student status because they take a medically necessary leave of absence from school. As a result, if your child is no longer a student, as defined in the plan documents, because he/she is on a medically necessary leave of absence, your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

(a) Begins while the child is suffering from a serious illness or injury;
(b) Is medically necessary, and
(c) Causes the child to lose student status for purposes of coverage under the plan.

The coverage provided to a dependent child during any period of continued coverage:

(a) Is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and
(b) Stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the plan is changed during this one-year period, the plan must provide the changed coverage of the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

COBRA Continuation Coverage

If your child is eligible for Michelle's Law's continued coverage and loses coverage under the plan at the end of the continued coverage period, continuation coverage under COBRA will be available at the end of the Michelle's Law's coverage period and a COBRA notice will be provided at that time. Continuation coverage will also, or alternatively, be made available as required by applicable (and only if applicable) state law.

Questions

If you have any questions regarding the information in this notice or your child's right to Michelle's Law's continued coverage, or if you would like a copy of your Summary Plan Descriptions (which contains important information about plan benefits, eligibility, exclusions, and limitations), you should contact the plan administrator at T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

WORKERS COMPENSATION

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation insurance laws or similar legislation. For workers' compensation related inquiries contact Human Resources.

PROHIBITION AGAINST DISCRIMINATION BASED ON A HEALTH FACTOR

Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on an item related to your health. (health status-related factors). Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Also, HIPAA prohibits group health plans and health insurers from discriminating with regard to eligibility (which includes benefits), premiums, or contributions based on any health status-related factor. Health status-related factors may include such things as health status, medical condition, claims, experience, receipt of health care, medical history, genetic information, evidence of insurability (EOI - which includes participation in dangerous activities such as motorcycling, horseback riding, and skiing), disability and any other health status-related factor determined appropriate by the Secretary of HHS.

Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual. For example, some things that may be prohibited include, but are not necessarily limited to, applying an actively-at-work or continuous service provision to exclude from coverage a person who is absent due to a health status-related factor, excluding an otherwise-eligible dependent under a hospital non-confinement or normal life activity provision, making eligibility for late enrollees or for a particular coverage option (e.g., an HMO) contingent on evidence of insurability, excluding individuals from coverage because they participate in dangerous, activities, excluding individuals from coverage due to a history of high health claims, charging individuals different premiums or imposing different costs based on the existence or absence of a health status-related factor.

Although differences in eligibility and premiums or contributions cannot be based on health status related factors, HIPAA allows group health plans to impose benefit restrictions that apply to all similarly situated individuals. For example, a plan may require participants to satisfy a deductible, co-payment, coinsurance, and other cost-sharing requirements. A plan may also limit or exclude benefits for specific conditions or diseases, for certain types of

treatments or drugs, or based on a determination that the benefits are experimental or not medically necessary. However, any limits or exclusions may not be directed at individual participants based on health status-related factors.

Questions: If you have any questions regarding the information in this notice, or if you would like a copy of your Summary Plan Descriptions (which contains important information about plan benefits, eligibility, exclusions, and limitations), you should contact the plan administrator at T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

WHCRA NOTICE

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and

Treatment of physical complications of the mastectomy, including lymphedemas. For example, this may include certain benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetric between the breasts, prosthesis, and complications resulting from a mastectomy, including lymphedema(s).

These benefits and/or coverage may be subject to the same deductibles and coinsurance provisions, as may be deemed applicable to and are consistent with other medical and surgical benefits provided under your medical plan, program, component, and/or option (as appropriate for your circumstances). Information on deductibles and coinsurance can be found in your SBCs, in your open enrollment materials, the Summary Plan Description (SPD), and any applicable Summary of Material Modification to the applicable SPD.

Questions: If you have any questions regarding the information in this notice, or if you would like a copy of your Summary Plan Descriptions (which contains important information about plan benefits, eligibility, exclusions, and limitations), you should contact your insurer or the plan administrator at T.L. Cannon Corporation, Attention Benefits administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

INFORMATION REGARDING
TERMINATION OF HEALTH PLAN COVERAGE FOR CAUSE

Your (and/or your dependents') coverage under the medical plan may be rescinded (i.e., canceled or discontinued with a retroactive effective date) if you (and/or your dependent) performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material information as prohibited under the terms of this Plan (i.e., in enrollment materials, a claim or appeal for benefits or in response to a question from the Plan Sponsor or Plan Administrator or each of their delegates).

Failure to inform the Plan Sponsor or Plan Administrator that you or your dependent is covered under another group health plan or providing false information to obtain coverage for an ineligible dependent are examples of actions that constitute fraud or intentional misrepresentation of material information. You will receive a thirty (30) calendar-day written notice prior to any coverage being rescinded.

MAMMOGRAM COVERAGE

The New York State Breast Cancer Detection law expanded the mammography benefits that certain insured health care programs must offer (i.e., no deductible, coinsurance or copayments) for certain items such as:

-Additional breast cancer screenings (beyond an initial screening mammogram)
-Diagnostic mammograms
-Breast ultrasounds
-Magnetic resonance imaging (MRI)

The new law may apply to services rendered by in-network providers regardless of age, sex, medical history or whether you received services in or outside of New York State. Further, effective February 20, 2018, certain 3-D mammograms may also receive special coverage if provided by an in-network provider.

If you have a family history of breast cancer, speak to your OB/GYN or primary care physician about how often you should be screened.

One caveat on this new insurance bill, is that employer plans set up as "self-funded" (are generally Exempt from state insurance laws. This means coverage is not required to be extended as required by the new law (including payment terms).

Because the Plan offers several coverage options, this summary is not intended to guarantee you coverage and/or payment for such items, but rather to inform you about the law so you may determine the benefits/coverage available to you.

If you would like to know your coverage/benefits for mammograms under the Plan, you should contact your insurer or the plan administrator at plan administrator at T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

Current law requires a certain minimum length of hospital confinement in conjunction with childbirth. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section delivery.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Questions: If you have any questions regarding the information in this notice, or if you would like a copy of your Summary Plan Descriptions (which contains important information about plan benefits, eligibility, exclusions, and limitations), you should contact the plan administrator at T.L. Cannon Corporation, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221.

AGENCY REQUIREMENTS & UPDATING ELIGIBILITY INFORMATION

This is a reminder that you must notify Human Resources to update dependent information by

submitting the required documentation, updating information provided as it applies to your specific circumstances, and signing the required forms. Why is this important? It is important because TLC is required to have the Social Security Number for all dependents covered by plans/programs that it sponsors. If you did not include the Social Security Number when you first enrolled your dependents, please be sure to provide the Social Security Number now to Human Resources.

Various laws require TLC and/or the plans/programs sponsored by TLC to report Social Security information (e.g., numbers, etc.) and other information concerning individuals covered by a plan/program sponsored by TLC. For example, the Centers for Medicare & Medicaid Services (CMS) requires insurers and certain plans to report to the Centers for Medicare & Medicaid Services (CMS) the Social Security Numbers of all individuals who are age forty-five (45) or older covered by group health plans. Further, the IRS and Health Care Reform (aka ACA) and the IRS also require TLC to report dependent information to the IRS for various purposes.

Because of this, if you have a dependent covered under a TLC sponsored plan/program and have not provided a valid Social Security number, you must update your dependent's information by contacting T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118 or by logging onto Benetrac online (http://www.paychexflex.com) with your assigned user name and password. You must complete any applications, forms, or statements that plan representatives request in the normal course or as specified and the Plan will rely on the information you provide. This means that if you incur a penalty because you failed to provide TLC with information (and/or timely update your information with TLC), it will be because of your own failure to provide the necessary information.

If you prefer, you may also update this information in writing by contacting Human Resources. Updating your dependent's information allows the Plan to accurately report to various governmental agencies that require such information (e.g., the Centers for Medicare & Medicaid Services and the Internal Revenue Service).

Please Note: As in the past, TLC may decide to conduct eligibility-type audits and/or verification process in accordance with all applicable law(s). For example, if you have dependents of any age covered under the Plan, do not be surprised if you are asked to provide documentation confirming their eligibility to participate in the Plan and to ensure proper tax reporting. We routinely monitor eligibility to help ensure that only eligible dependents are covered. Providing a simple document such as a birth certificate may assist us in keeping our records up to date.

REMEMBER: You are responsible for promptly reporting dependent information to TLC. This includes, but is not limited to, reporting to TLC that you have a dependent (and timely updating the information you provide), that you lose a dependent and/or a dependent's loss of eligibility for coverage (e.g., due to divorce, exceeding a maximum age limit, etc.) by contacting T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118 or by logging onto Benetrac online (http://www.paychexflex.com) with your assigned user name and password.

TLC retains all discretion, rights and authority to perform such eligibility audits and to determine appropriate procedures and requirements of such eligibility audits in accordance with applicable law(s). Further, the Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable).

If you need any additional information or have any questions, please contact T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

FRAUD STATEMENT

Identity theft and hacking consistently make the national headlines (e.g., Experian, Yahoo!, Target, Home Depot, etc.) Please be sure to regularly check your explanations of benefits and/or claim statements (EOBs). EOBs usually show that the Plan was billed for, what the Plan paid and what, if anything you may owe. Also, if a medical provider charges for services that were not rendered, they could be committing health insurance fraud. If anything looks inaccurate or suspicious, please contact your Plan Administrator at 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118 for additional information.

MEDICARE STATEMENT

Entities that provide prescription drug coverage to Medicare Part D eligible individuals must notify these individuals whether the drug coverage they have is creditable or non-creditable. This notice describes if the drug coverage provided is creditable or non-creditable, which generally means that the coverage is expected to pay on average as much as the standard Medicare prescription drug coverage. You should receive this statement/notice each year if you have drug coverage from an employer/union or other group health plan (and in other limited situations). If you have not received this notice, please contact Human Resources as soon as possible.

You should keep the notice. You may need it if you decide to join a Medicare drug plan later. You should keep the notice. You may need it if you decide to join a Medicare drug plan later. This notice is important because Medicare beneficiaries who are not covered by creditable prescription drug coverage and do not enroll in Medicare Part D when first eligible will likely pay higher premiums if they enroll at a later date. Although there are no specific penalties associated with this notice requirement, failing to provide the notice may be detrimental to employees.

This notice generally only applies to individuals (and/or their dependents) who have Medicare or will become eligible for Medicare in the next 12 months. In such circumstances, a federal law may provide you with additional choices about your prescription drug coverage. A notice with summaries and additional information was provided by the Plan in a separate mailing. If you did not receive a notice and/or if you need any further information, have any questions, or if you would like another copy of the full notice, please contact the Plan Administrator at T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

PATIENT PROTECTIONS NOTICE
Aka Primary Care Physicians (PCPs) and OB/GYN Care Notice, etc.

This notice applies only to the extent that any of the medical options under the Plan are subject to its requirements.

To the extent that any of the medical plan options allow for the designation of a primary care provider, you have the right to designate any primary care provider who participates in the applicable medical plan option's network of providers and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, the medical plan option may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your medical plan carrier.

You do not need prior authorization from your medical plan carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the network of your medical option who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Excellus https://www.excellusbcbs.com/wps/portal/xl/mbr/fnd/doctor/ (1-877-253-4797) and Independent Health https://www.independenthealth.com/IndividualsFamilies/FindADoctor.aspx (1-800-501-3439).

Furthermore, you do not need prior authorization from the Plan, you medical carrier, or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the applicable medical program's network (as applicable) who specializes in obstetrics or gynecology in the applicable medical plan's network. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact (as applicable to your situation):

1. Excellus https://www.excellusbcbs.com/wps/portal/xl/mbr/fnd/doctor/ (1-877-253-4797)

or:

2. Independent Health https://www.independenthealth.com/IndividualsFamilies/FindADoctor.aspx (1-800-501-3439).

WELLNESS PROGRAM

TLC offers various voluntary wellness program benefits under the T.L. Cannon Corporation Group Insurance Plan, a benefit plan contained under the TLC Wellness Program (the "Wellness Program"). These benefits are referred to herein as ("Voluntary Wellness Benefits").

TLC's Voluntary Wellness Benefits are purely voluntary. Various notices may be required to be provided when an employer sponsors a wellness program. TLC wants you to know that the wellness program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and/or the Health Insurance Portability and Accountability Act, as applicable, among others.

The ADA requires wellness plans that may collect health information or involve medical exams to provide a notice to employees that explains how the information will be used, collected, and kept confidential. Employees must receive this notice before providing any health information and with enough time to decide whether to participate in the program. This is why TLC is providing you this notice at this time.

In order to provide the Voluntary Wellness Benefits, the Plan must obtain certain types of Wellness Medical Information.

Wellness Medical Information That May Be Obtained By the Plan.

The Wellness Medical Information obtained will depend on the elections made by a participant (or beneficiary, only as applicable) and whether he/she decided to voluntary participate and provide such Wellness Medical Information.

The Voluntary Wellness Benefits are currently structured to obtain the information needed to administer programs for smoking cessation; obesity and weight management; exercise-related habits; disease management criteria, conditions, and utilization of benefits; counseling related issues through the employee assistance program (only as applicable); information obtained through blood draws; physical examinations and biometric screenings; and immunizations (e.g., flu clinics). However, please keep in mind that T.L. Cannon only receives Wellness Medical Information in aggregate form that does not disclose, and is not reasonably likely to disclose, the identity of specific employees.

How the Wellness Medical Information Will Be Used.

Any Wellness Medical Information will be used solely to administer the Voluntary Wellness Benefits under the Plan. The applicable vendors that agreed to be bound by Business Associate Agreements (BAAs) in accordance with the health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. Further, your employer (T.L. Cannon) will only receive Wellness Medical Information in aggregate form that does not disclose, and is not reasonably likely to disclose, the identity of specific employees.

Protections From Disclosure of Wellness Medical Information.

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and TLC may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information will do so in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

Lastly, if you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact call T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

Other Considerations

TLC will also provide reasonable accommodations that enable employees with disabilities to participate and to earn whatever incentives offered by the Plan. For example, if T.L. Cannon offers an incentive for employees to attend a nutrition class, then T.L. Cannon will, absent undue hardship, provide a sign language interpreter for a deaf employee who needs one to participate in the class. Other examples include providing materials related to an employee assistance

program in alternate format (such as large print or Braille, for someone with vision impairment) or providing an employee with an alternative to a blood test if an employee's disability would make drawing blood dangerous.

Your health plan is committed to helping you achieve your best health. Rewards for participating in an employee assistance program are available to all employees choosing to participate in the applicable employee assistance programs. If you think you might be unable to meet a standard for a reward under an employee assistance program or if it may be inadvisable for you to attempt to achieve the standards for the reward under this program, you might qualify for an opportunity to earn the same reward by different means.

If you think you might be unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. **You may request a reasonable accommodation or an alternative standard by contacting** T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118. We will work with you to develop another way to qualify for the reward.

Lastly, if you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact call T. L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

In certain limited circumstances, an enrollment may occur outside the annual open enrollment period. The Plan's notices contain information about your special enrollment rights. In general, you have special enrollment rights if you acquire a new dependent, or if you decline coverage under the health plans/programs sponsored by TLC for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Please note: The 30- and 60- day deadlines described below may be extended due to the COVID-19 national emergency. Accordingly, there may be some differences in how such situations are handled due to these special rules. Under this adjustment, days during the COVID-19 outbreak period are generally disregarded for purposes for purposes of calculating the 30- and 60- day special enrollment deadlines. The COVID-19 outbreak period is the period from March 1, 2020, until 60 days after the end of the COVID-19 national emergency. However, the disregarded period associated with any particular special enrollment event will not exceed one year. This may end during 2023 and you will be notified in such situations. For further detail on the effect of the COVID-19 emergency on the special enrollment deadlines, contact T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

Loss of Other Health Coverage (Except Medicaid or State Children's Health Insurance Program)

If you decline medical plan enrollment for yourself or your eligible dependents (including your eligible spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in the TL Cannon plan, if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after the date your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Eligibility Under Medicaid or a State Children's Health Insurance Program)

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your eligible dependents' coverage ends under the Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents in the TL Cannon plan. However, you must generally request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program (CHIP) or Medicaid

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this Plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

***Please note that the Plan does not (and will not) accept state premium assistance subsidies directly from an agency, but will follow applicable law(s), requirements, guidance, and responsibilities (in the sole discretion of the Plan Administrator).**

If you need any additional information or have any questions, please contact T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

Midyear Change to Part-Time Status; Reduced Hours; & Exchange Enrollment

Separate notices will provide special enrollment rights for specific situations due to enrollment in a Qualified Health Plan. These situations are limited to circumstances where:

1. The employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

2. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Special rules also apply for a Midyear Change to Part-Time Status and Reduced Hours. A separate notice will describe such events, program operations for such events, and the requirements necessary for such events.

As of April 1, 2009, the plans subject to this requirement (generally health) must allow a HIPPA special enrollment for employees and dependents who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible or they become eligible for a state's premium assistance program. Employees have 60 days from the date of the Medicaid/CHIP event to request enrollment under the plan. Please see the Medicaid and Children's Health Insurance Program notice and/or the Premium Assistance Under Medicaid and the Children's Health Insurance Program Notice.

For more information, call T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

PREMIUM ASSISTANCE

UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Certain employees that they may be eligible for premium assistance from through CHIP or Medicaid state programs. Please read this notice carefully and keep a copy for your records

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health **plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –**.

ALABAMA – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-

	insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**

Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1 855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email bsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 4/31/2023)

HEALTH INSURANCE MARKETPLACE COVERAGE AND YOUR HEALTH COVERAGE

You can buy health insurance through the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer. Please note that this notice it based off of a model form provided by the government; however, due to recently released guidance in the form of Final Regulations concerning premium assistance in the Marketplace certain portions of this notice should be modified to the new guidance. We note this because the government has not yet provided an updated notice, but has kept the requirement that employers provide this notice in open enrollment materials. Because of this, you should consult your own advisors to determine if you and/or your family are eligible for premium assistance in the marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers generally provides "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on My Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings Through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace* and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% (as adjusted, if applicable) of your household income for the year (or applicable limit as these limits may change year to year), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.*[2] Your employer's health plan satisfies the minimum value standard, and the cost of this health plan to you is intended to be affordable, based on employee wages when looking at employee-only coverage.

[2] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Final regulations were released by the government concerning family premium tax credits so you should talk to your advisors concerning applicability to your circumstances. This is important information about health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about coverage offered through TL Cannon, please check your summary plan description/supporting documents and any applicable benefit booklets, insurance booklets/documents, summaries of material modification, notices, summaries of benefits and coverage, etc. or contact the Pan Administrator at Benefits Administrator/Analyst, 716.634.7700 x8118

Also, the Marketplace and your advisors can help you evaluate your coverage options (especially given recent changes concerning family affordability described in "Family Affordability"), including your eligibility for coverage through the Marketplace and its cost (including the impact of the new Final Regulations that were recently released in October 2022) Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a health insurance marketplace in your area

Family Members and Affordability: Please note that the IRS recently (October 13, 2022) published final regulations that change the eligibility standards for an Affordable Care Act (ACA) premium tax credit (PTC). These new rules apply for taxable years beginning in 2023 and state that affordability of employer-sponsored coverage for an employee's family members is based on the employee's cost to cover the employee and those family members, rather than the cost of employee-only coverage. This means that the IRS has concluded that the ACA should be interpreted to require separate affordability determinations for employees and for related individuals.

Under the new rules, employer plan affordability for family members will be based on the required cost for the entire family to participate in the employer-sponsored plan, effective January 1, 2023. However, affordability for the employee will continue to be based on the employee's cost for single (employee-only) coverage. Depending on the employer's contribution, you should be aware that this could create a situation where family members are eligible for the premium tax credit by purchasing individual coverage, while the employee remains ineligible based on the cost of single coverage.

At this time there are no employer penalties for unaffordable family coverage and employer reporting requirements generally are unmodified. At this time, employer penalties are based only on the cost of single or employee-only coverage. Employers are not required to provide affordable family coverage and will not be penalized in cases where family members receive the premium tax credit when purchasing individual health insurance.

Because of this, you should contact your advisors to determine the best course of action for you and your family. This is an evolving situation and we will provide additional information.

*An employer-sponsored health plan generally meets the minimum value standard if the plan's share of total allowed benefit costs covered by the plan is no less than 60% of such costs (based on applicable rules and adjustments as of the applicable date). (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

HOW TO DELIVER FORMS AND NOTICES

This Plan and the applicable service provider(s) require you to return or delivery various election and enrollment form and notices to the Plan Administrator or the applicable service provider(s) by specified due dates. It is important that you make certain the Plan Administrator actually receives the form or notice on a regular business day on or before the due date, at the address(es) stated in this document, with enough time to relay the form to the applicable service provider by the due date. Failure to do so will result in no coverage or a loss of coverage for yourself or your dependents or both.

ELIGIBLE EMPLOYEE'S RESPONSIBILITY TO FURNISH CURRENT ADDRESS(ES)

Each eligible employee is responsible for providing the Plan Administrator and each applicable service provider with the eligible employee's current address and the current address of each other person coverage through the eligible employee. Any notices required or permitted to be given to a participant shall be deemed to have been properly given if directed to the address most recently provided by the eligible employee and sent by first class United States mail. The insurer (if applicable), the Plan Administrator, and the Plan Sponsor shall have no obligation or duty to locate an eligible employee.

PARTICIPANT'S RESPONSIBILITIES

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

PREVENTIVE CARE BENEFITS

The ACA and its implementing regulations require non-grandfathered health plans to cover certain preventive health services and meet certain requirements without imposing cost-sharing requirements (that is, deductibles, copayments or coinsurance) for the services. This is based on specified medical and scientific guidelines. Health plans are required to adjust their first-dollar coverage of preventive care services based on the latest preventive care recommendations. If you have a non-grandfathered plan, you should confirm that your plan covers the latest recommended preventive care services without imposing any cost-sharing.

Now, more than ever, it's important to stay up to date on preventive care and seek medical help when you need it. Each plan options works somewhat differently. However, ACA requires certain preventive care to be covered at 100%. Preventive care includes services you receive to prevent illness or injury, such as (check your program for specifics):

- Routine exams (such as well baby visits and annual physicals for (children and adults)
- Health screenings, such as mammograms and colonoscopies
- Immunizations

In addition, on January 11, 2022, HHS issued a press release outlining updates to comprehensive preventive care and screening guidelines specific for women and infants, children, and adolescents. As such, most group health plans and insurance carriers (insurers) will be required to provide coverage for the updated services. For instance, group health plans and insurers must provide coverage for services integral to preventive colorectal cancer screenings with a rating of "A" or "B" by the United States Preventative Services Task Force (USPSTF). Coverage for all FDA-approved contraceptives is required (this is not a new requirement). Group health plans and insurers are also required to provide coverage without cost sharing of the new and updated services in the Women's Preventative Services Guidelines and the Bright Futures Periodicity Schedule, effective for plan years beginning in 2023. Plan implementation is only as required and as provided in the applicable Supporting Documents.

More information on the recommended preventive care services is available through the United States Preventive Services Task Force (USPSTF) and healthcare.gov or by contacting the plan administrator at T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700

x811

8.

W-2 INFORMATION & REPORTING

Various laws and legal mandates (e.g., Health Care Reform, the IRS, etc.) require TLC to report the cost of employer-sponsored health coverage (as well as other information) to various government agencies. If you are covered under the Plan this year, this amount will be reported on your W-2 Form. The amount reported will include both the portion you pay and the portion TLC pays. You will receive your W-2 in January of the following year. You do not need to take any action - this is being provided strictly for your information - you are not being taxed on this amount based on current tax laws. Please keep in mind that your accountant and/or tax advisor may ask for a copy of this document when you are completing your taxes.

The U.S. Treasury/IRS have also issued various regulations and mandates pertaining to the Health Care Reform (aka ACA) Employer Shared Responsibility provisions as well as regulations on the related Information Reporting by certain large employers (like TLC) and/or the insurance companies providing coverage under the applicable programs. Because of this, TLC may be is required to report certain employee and dependent information to the Internal Revenue Service in order to meet these requirements. Given the new regulations and guidance provided by government agencies applicable to the Plan, the Plan may need to revise and/or implement new requirements throughout the year. This is merely a reference so you are aware in case you see additional information reporting.

For instance, as a large employer, TLC may be required to file information returns with the IRS and provide statements to their full-time employees about the health insurance coverage offered by TLC. The IRS will use the information provided by TLC on the information return to administer the employer shared responsibility provisions of section 4980H. TLC is also required to submit another report to the Internal Revenue Service about the specific health coverage provided by TLC. The IRS and individuals will use the information provided on this report to administer or to show compliance with the individual shared responsibility provisions of the Health Care Reform law.

TLC is required to file these information returns with the IRS and furnish statements to employees and to report information about its offers of health coverage to its full-time employees. If you have any questions about your W-2 Form, please contact T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

PROGRAM CHANGES

The Employee Retirement Income Security Act (ERISA) requires T.L. Cannon **to provide this summary of material modifications which is a summary description of any material modification to the plan and any change in the information required by federal benefits law to be included in the summary plan description to each participant covered under the plan and each beneficiary receiving benefits under the Plan. Thus, the enclosed legally required notice addresses the modification being made to the Plan effective January 1, 2023.**

The changes reflected in this summary of material modifications (SMM) affect your eligibility and benefits under the Plan and should be kept with your benefit materials for future reference. Supporting Documents means the documents under which the Plan is operated, including, but not limited to, plan documents, trust agreements, group insurance policies, summary plan descriptions, summaries of material modifications (including but not limited to material reductions in covered services and benefits), certificates of coverage, benefit booklets, administrative service contracts, collectively bargained agreements, implemented final offers, open enrollment materials, handbooks, pharmacy benefit management contracts, and any other agreements or contracts (including but not limited electronic versions thereof) under which services or benefits under the Plan are provided, to the extent such separate documents set forth the terms and conditions of coverage for the Plan.

Electronic Forms and Notices

To facilitate efficient operations of the for the health/welfare plans sponsored by TLC as well as the cafeteria plan sponsored by TLC, the plans may allow forms and notices (including, for example, election forms and notices, disclosures, program notices, etc.), whether required or permissive, to be sent and/or made by electronic means. Such electronic forms and notices will be provided in accordance with all applicable laws and requirements applicable to such arrangements. You must complete any applications, forms, or statements that plan representatives request in the normal course or as specified and the Plan will rely on the information you provide.

Please note: The Federal Department of Labor has recently issued regulations to modify the electronic disclosure requirements. The latest regulations apply to retirement plans and not welfare benefit plans. TLC will monitor the regulatory process and change electronic processes and meet applicable requirements as necessary and required.

Program Changes & Health Care Reform

Certain of the benefit options offered by T.L. Cannon have been modified for the 2023 Coverage Year. Some of these are benefit changes while others have been made due to the health care reform law (aka PPACA) and/or other legal changes. You will receive more information on these changes in the Supporting Documents and in information provided to in the SBCs and directly by the insurance carrier(s) listed below. If you have questions about your benefit changes, contact T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

However, T.L. Cannon reserves the right at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add benefits or terminate the T.L. Cannon benefit plans and programs, as well as benefits under the Plans, the SPD and the Supporting Documents, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. To the extent required by the Employee Retirement Income Security Act (ERISA), if there is a material reduction in covered services or benefits under the Plan, the reduction will be disclosed to you no later than 60 days after the date on which the reduction is adopted.

The Plan's terms cannot be modified by written or oral statements to you from Human Resources representatives or other personnel. In the event of any discrepancy between the plan documents and this document or written or oral statements, the plan documents will govern.

Administrative Information

Plan Name and Number:	T.L. Cannon Corporation Group Insurance Plan
Plan Number:	501
Plan Situs:	As provided in the applicable documentation provided by the insurers providing coverage under the Plan.
Plan Sponsor and Administrator:	T.L. Cannon Corporation 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221 716.634.7700
Type of Plan:	The Plan is a health and welfare benefit plan providing health insurance, dental insurance, vision insurance, life insurance, temporary disability insurance, long-term disability insurance, death insurance (include travel and accident insurance) and accidental death and dismemberment benefits. Health FSA benefits are provided by a program sponsored by T.L. Cannon Corporation under a separate plan called the T.L. Cannon Corporation Premium Only Plan.
HSA Custodian:	Key Bank HSA Operations PO Box 1300 Buffalo, New York 14240-1300 (888) 539-2020 Although the HSA is offered along with benefits provided by the Plan, the HSA is administered through a separate plan called the T.L. Cannon Corporation Premium Only Plan and the HSA consists of only a method to allow Participants to contribute to a health care savings account established by an Employee with a third-party vendor *Link also provided in Benetrac http://www.paychexflex.com
Plan Administrator's Employer Identification Number:	59-3005084
Plan Year:	January 1 Through December 31
Coverage Year:	January 1 Through December 31
Funding and Administration:	The cost of the Plan is funded as follows: For employee and dependent coverage, funding is derived from the funds of the employer and contributions

	made by the covered employees. The level of any employee contributions will be set by the Plan Administrator. These employee contributions will be used in funding the cost of the Plan (or component benefit plan/program, as applicable) as soon as practicable after they have been received from the employee or withheld from the employee's pay through payroll deduction. Benefits are also paid directly from the Plan (or component benefit plan/program, as applicable) through the claims administrator. Health, dental, vision, life, temporary disability, long-term disability, death and accidental death and dismemberment benefits provided through contracts with an insurance company. Certain High Deductible coverage under the Plan is coupled with a health savings account under a separate plan (which consists of only a method to allow Participants to contribute to a health care savings account established by an Employee with a third-party vendor). Wellness Program benefits and Employee Assistance Program benefits are not insured benefits; however, they are provided to T.L. Cannon free of charge due to T.L. Cannon's relationship with insurers (identified below).
Refunds, Rebates, Demutualization and Similar items	Administered via policies and procedures contained in the Plan Document at the sole discretion of the Plan Administrator. The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable).
Dividends	Administered at the sole discretion of the Plan Administrator. Any dividend paid (directly and/or indirectly) under the Plan will be the property of the Company, regardless of how the Plan is funded, unless otherwise determined by the Plan Administrator. Appropriate disclosures will be made to Plan participants as required by law and applicable guidance. The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable).
Subrogation, Coordination of Benefits,	Administered via policies and procedures contained in the Plan Document at the sole discretion of the Plan Administrator. The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable).
Offsets	Applicable information provided in the Supporting Documents. The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable).
Source of Contributions:	Plan contributions may be made by the Employer and/or the Employee depending on options and benefits elected. The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and

	interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable).
Collective Bargaining Agreements:	Not applicable.
Insurance Carriers for Group Health Benefits:	Excellus BlueCross BlueShield P.O. Box 22999 Rochester, NY 14692 Call 1-800-499-1275 excellusbcbs.com Independent Health 511 Farber Lakes Drive Buffalo, NY 14221 (716) 631-3001 Group Name: T.L. Cannon Corporation toll free 1.800.501.3439 / Local 716.631.8701 medical help 1.800.501.3439 (24-hour line) Email memberservice@servicing.independenthealth.com
Insurance Carrier for Dental:	Guardian PO Box 824404 Philadelphia, PA 19182-4404 1-800-541-7846 Policy: 419399
Insurance Carrier for Vision:	Guardian PO Box 824404 Philadelphia, PA 19182-4404 1-800-541-7846 Policy: 419399
Insurance Carrier for Life Insurance & AD&D:	Cigna 900 Cottage Grove Road Bloomfield, CT 06002 Tel: 1.800.238.2125 ext. 5059012 Fax: 1.866.517.9874 Policy: 960282
Insurance Carrier for Short-Term Disability:	Guardian – New York Mandated PO Box 14331 Lexington, KY 40512 Tel: 800-268-2525 Fax: 610-807-8270 Policy: 960282

	Guardian – All Other PO Box 824404 Philadelphia, PA 19182-4404 1-800-541-7846 Policy: 419399
Insurance Carrier for Long-Term Disability:	Cigna 900 Cottage Grove Road Bloomfield, CT 06002 Tel: 1.800.238.2125 ext. 5059012 Fax: 1.866.517.9874 Policy: BNK960095
Insurance Carrier for Death Benefits (including travel / accident)	Guardian PO Box 824404 Philadelphia, PA 19182-4404 1-800-541-7846 Policy: 419399
Administrator for Wellness:	Excellus BlueCross BlueShield P.O. Box 22999 Rochester, NY 14692 Call 1-800-499-1275 Independent Health 511 Farber Lakes Drive Buffalo, NY 14221 (716) 631-3001 The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable).
Administrator for Employee Assistance Benefits:	Guardian PO Box 824404 Philadelphia, PA 19182-4404 1-800-541-7846 Policy: 419399
Statute of Limitations:	All claims for benefits must be submitted by the claims filing deadline specified under the rules for a particular program under the Plan. If the program does not specify a filing deadline, then claims must be submitted within one year from the date the services relating to the claim were performed or the event that gave rise to the benefit occurred. This requirement may be waived by the Plan if, through no fault of the claimant, the claim is filed after the deadline but is filed as soon as practicable and within a reasonable time period, given the particular circumstances. Except in the case of legal incapacitation, late claims

will l not be accepted if they are filed more than one year form the date the services relating to the claim were performed or the event that gave rise to the benefit occurred.

Except as noted in the claims procedures, a claimant may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Plan Sponsor, or any other person, with respect to a claim for disability, medical, or other claims for benefits without first exhausting any applicable claims procedures as set forth herein and/or by a service provider and such determination will be made at the sole discretion of the Plan Administrator. A claimant who has exhausted the applicable claims procedures and is dissatisfied with the decision on appeal of a denied claim may bring an action under section 502 of ERISA in an appropriate court to review the Plan Administrator's decision on appeal but only if such action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the decision on appeal. No legal action may be commenced or maintained to recover benefits under the Plan more than one year after the Plan's final decision on appeal. In the event any underlying provisions mandated by service providers conflict with this section the service provider rule will control as determined in the sole discretion of the Plan Administrator.

Anti-Assignment:

Except for voluntary assignments to health care providers as may be required by law or as may be provided by applicable programs, the right to receive benefits under any of the programs contained in Plan may not be assigned, voluntarily or involuntarily, to any other person other than the applicable participant. A direct payment by the Plan to a person or entity that provides medical services to a Plan participant is not a waiver of this provision. Additionally, a medical service provider may not bring a claim for benefits against the Plan, a Plan fiduciary, the Plan Administrator, or an employer with respect to the services it provides to a Plan participant.

Agent for Service of Legal Process:

T.L. Cannon Corporation
180 Lawrence Bell Dr., Suite 100,
Williamsville, New York 14221
716.634.7700
Legal Process may also be served on the Plan Administrator.

Your Questions:

If you have any general questions regarding the plan, including, for example whether you are eligible to participate in the plan or particular benefit plan or program offered through the plan, please contact Human Resources, your Plan Administrator: Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118. (who acts on behalf of the Plan Administrator). For insured benefits, you may also contact the appropriate Insurance Company (information provided herein).

The terms of the Plan and this SPD shall be construed, interpreted, and administered in a manner which meets the minimum requirements of the law, including but not limited to, PPACA, ERISA, the Internal Revenue Code, etc.

Due to a change in the law, the Plan may only rescind coverage retroactively in cases involving fraud or an intentional misrepresentation of material facts, as determined in the sole discretion of the Plan Administrator on a uniform and consistent basis. The Plan will follow all applicable law in administering this requirement including the requirement to provide thirty (30) days advance notice of any rescission of coverage.

Please note that the Plan Administrator may also reduce your contributions and/or tax certain benefits provided under the Plan if you are a key employee or highly compensated individual as defined by the Internal Revenue Code, if necessary, to meet the applicable nondiscrimination provisions under Federal income tax law. Keep in mind that these laws may change throughout the year, especially in these uncertain times. In such situations, the Plan will be interpreted based on guidance released and the Plan Administrator will interpret provisions as necessary, on a uniform and nondiscriminatory basis, for the operations of the Plan.

Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the account of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Plan and applicable law. Such action by the Plan Administrator may include coordination with the withholding of any amounts due from your compensation under the applicable plan.

If you have any questions regarding these notices, please feel free to contact Human Resource Department, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

Power and Authority of Insurance Companies

For 2023, certain benefits under the plans sponsored by TL Cannon are fully insured. These insured benefits are provided under group insurance contracts entered into between a TL Cannon entity and the applicable insurance companies. Claims for benefits under these component benefit plans and programs are submitted to the insurance companies. The insurance companies (not TL Cannon) are responsible for determining and paying claims with regard to insured plans and programs. To provide further clarification, for each of the insured component benefit programs, the applicable insurance company is a named fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the applicable insurance contract.

Further, the applicable insurance companies are responsible for determining eligibility for a benefit and the amount of any benefits payable under the insured plans/programs sponsored by TL Cannon. The insurance companies also provide the claims procedures to be followed and the claims forms to be used by eligible individuals with respect to insured benefit plans and programs. This means that the insurance companies are named fiduciaries under the plans/programs sponsored by TL Cannon to the fullest extent permitted by law and the insurance companies are therefore provided with the discretionary authority to interpret the plans/programs in order to make such benefit determinations. The insurance companies also have the authority to require eligible individuals to furnish them with such information as they determine necessary for the proper administration.

Clerical Error

Clerical error, whether of the employer, Plan Sponsor, and/or Plan Administrator, and/or vendor of any of such entities in keeping any record pertaining to the coverage hereunder, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated unless otherwise required by coverage documentation or policy (e.g., fraud, rescission, etc.). Further, any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable).

Waiver of Coverage

You have the option to waive benefits coverage with TLC. To waive coverage, you must actively elect to waive coverage in the online enrollment system by your enrollment deadline, verifying you are waiving coverage. If you do not actively elect to waive coverage, coverages will continue as provided by the Default Rules (existing employees) or you will be defaulted into no coverage (new employees and or newly eligible employees).

If you waive coverage, all of the following will apply:
-You waive coverage for yourself and for all eligible dependents.
-You waive all mandatory and optional Choices coverages.
-You forfeit the monthly employer contribution toward benefits coverage.
-You and your eligible children cannot re-enroll unless and until you have a qualifying event or until the next annual enrollment period.
-Your legal spouse cannot be added to the Plan unless and until they have a qualifying event.

If you default coverage, your coverage will be defaulted pursuant to the default rules listed above (which may leave you with no coverage what-so-ever).

Waiver

No agent or other person, except the Plan Administrator has the apparent or express authority to waive any conditions, provisions or restrictions of the plan and/or program sponsored by TLC to extend the time for making a payment, or to bind any plan and/or program by any promise or representation made by giving or receiving any information. The waiver of any condition, provision or restriction of the Plan or of the waiver of a breach of any provision hereof shall not be deemed a waiver of any other condition, provision, restriction or breach hereof.

Claims Procedures

Claims and Appeals for Fully Insured Benefits

The Insurance Company is responsible for evaluating all benefit claims under the Plan. The Insurance Company will decide claims in accordance with its reasonable claims procedures, as required by ERISA and other applicable law(s). For purposes of determining the amount of, and entitlement to, benefits of the component benefit plans and programs provided under insurance contracts, the respective insurer is the named fiduciary under the plans/programs sponsored by TL Cannon, with the full power to interpret and apply the terms of the such plans/programs as they relate to benefits provided under the applicable insurance contract. The Insurance Company has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide a claim. If the Insurance Company denies a claim, in whole or in part, the claimant will be provided notice of the decision. The certificate of insurance booklet issued by the insurer provides information about how to file a claim and details regarding the insurer's claims procedures. For any questions about your insured coverage, please contact the applicable insurer.

To obtain benefits from the insurer of a component benefit plan or program, you must follow that insurer's claims procedures. The insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. The insurer has the right to secure independent medical advice and to

require such other evidence as it deems necessary in order to decide a claim. If the insurer denies your claim, in whole or in part, the claimant will be provided written notice of the decision.

If your claim is denied, you may appeal to the insurer for your view of the denied claim. The insurer will decide your appeal in accordance with its reasonable claims procedures as required by ERISA (if ERISA applies) and other applicable law. ***Please keep in mind, if you do not appeal on time, you may lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally may be a prerequisite to bringing suit in state or federal court).***

Please also note, under certain component benefit plans or programs you may also have the right to obtain external review that is a review that may be outside of the T.L. Cannon Group Insurance Plan which is a health and welfare benefit plan under ERISA. Again, please see your certificate of insurance booklet issued by the insurer for information about how to appeal a denied claim and for details regarding the insurer's claims procedures.

The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable).

Claims and Appeals for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the self-funded component benefit plans/programs sponsored by TL Cannon (from general assets), the Plan Administrator is the named fiduciary under the plans/programs sponsored by TL Cannon, with the full power to make factual determinations and to interpret and apply the terms of such plans/programs as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must submit a claim to the Plan Administrator print (or if applicable, the Claims Administrator for that particular benefit) in accordance with the claims procedure for that component benefit plan or program. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with the claims procedures for the applicable component benefit plan or program. For component benefit plans or programs that are subject to ERISA, the claims procedures will be reasonable and will comply with the applicable requirements. If the Plan Administrator denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Plan Administrator for review of the denied claim. The Plan Administrator will decide your appeal in accordance with reasonable claims procedures, as required by ERISA (if ERISA applies). If you do not Appeal on time, you may lose your right to file suit in state or federal court, because you will not have exhausted your internal administrative appeal (which generally may be a prerequisite to bringing a suit in state or federal court).

The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable).

Claims procedures have been and will continue to be updated for recent guidance on surprise medical billing requirements as the information and requirements become applicable and available. This includes regulatory guidance on the requirement that external review be applied for adverse benefit determinations relating to a surprise medical bill and implementation of FAQs addressing disclosure (including on EOBs) regarding the surprise billing protections.

The Plan, including the component benefit plans and/or programs, is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and TL Cannon (or any TL Cannon entity) for employment.

Long-Term Disability Benefits: **Summary**

In generally, if you are eligible for and properly elect long-term disability benefits, meet all pre-requisites and pay applicable amounts, benefits under this plan may be payable if you're ill or injured and unable to work for the required time frame (as described in the underlying documentation). This is explained in greater detail in the LTD documents provided to you at orientation and open enrollment, etc.

How to File a Disability Claim

File your claim by contacting the Insurance Carrier for Long-Term Disability Benefits (see the Administrative Information section herein or information below).

Be prepared to provide certain information.

The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable).

Outbreak Notice

Timing Extensions Expiring For HIPAA Special Enrollment Events, COBRA Coverage and ERISA Claim and Appeals

The U.S. Department of Labor and IRS announced temporary extensions of certain plan deadlines during the COVID-19 pandemic. This required ERISA health and welfare plans to extend various deadlines during the "outbreak period" related to the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), special enrollment, and claims and appeals, including external review procedures. Under these extensions, plan participants and dependents were given extra time to make HIPAA Special Enrollment election changes, file ERISA claims and appeals, receive notifications about COBRA elections, and make COBRA premium payments. This temporary extension became effective on March 1, 2020 and created individual extension deadlines.

The "outbreak period" ends on the earlier of (1) one year from the date an individual is first eligible for relief, or (2) 60 days after the announced end of the COVID-19 National Emergency. This leads to individual one-year extensions of the deadlines referenced above while the COVID-19 National Emergency is ongoing. When the COVID-19 National Emergency ends, you will be notified about the end of any applicable deadline extensions.

What this means for you and your family: Only as applicable to the plans and programs sponsored by TLC, during the period that began March 1, 2020 to present, individual timing extensions can only be extended for a maximum of 12 months. If the original deadline would have been on or after March 1, 2020, your new deadline will now be one-year from your original deadline. However, this special relief may be ending in 2023. If it does, the Plan will notify impacted participants about the need of any applicable deadline extensions

As we notified you before, your deadline could end sooner than one year once the National Emergency declaration ends. Accordingly, if you delayed any of the applicable items (e.g., requesting enrollment under the plan due to a HIPAA special enrollment event, filing an ERISA claim or appeal, enrolling in or making a premium payment(s) for continuation coverage), you should act quickly or you may lose your ability to exercise your rights under the Plan.

Questions or If You Are Not Sure If/How This May Apply to You?
For more information, contact Human Resources, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118

Health Savings Account: General Notice

PLEASE NOTE: Your health savings account is not part of this plan and is not subject to ERISA. The following information is provided for your convenience only.

A health savings account is a trust or custodial account that qualifies as a "health savings account" under the Internal Revenue Code. Very generally, an individual who has high deductible health plan coverage under a high deductible coverage option sponsored by TLC, and who meets the other Internal Revenue code requirements, can make pre-tax or deductible contributions to a health savings account and then take distributions from the account tax free to pay for qualifying medical expenses incurred after the establishment of the account by the individual or the individual's spouse or certain dependents. The individual may take distributions for other purposes, subject to income tax and, in certain cases, penalties. Funds in a health savings account are not subject to forfeiture and remain available for distribution to the owner even if the individual is no longer eligible to contribute to the account, and for distribution after the owner's death to appropriate estate or beneficiary.

To establish a health savings account, an individual must make arrangements with a trustee or custodian (outside of the Plan).

You may establish your health savings account with the elected health savings account custodian. The custodian will administer your health savings account. The Plan Sponsor and your employer's only responsibility with respect to your health savings account is to send your contributions to the custodian.

If you enroll in a program that is eligible for an Health Savings Account/HSA, you will then be allowed to open a Health Savings Account (HSA) to help pay for eligible medical expenses. A HSA is a deposit account that you can use to pay for qualified medical expenses – tax-free. Plus, the HSA account is yours to keep – the money you save will roll over year to year.

If you enroll in a program that is eligible for a Health Savings Account/HSA, you will then be allowed to open an Health Savings Account (HSA) to help pay for eligible medical expenses. A HSA is a deposit account that you can use to pay for qualified medical expenses – tax-free. Plus, the HSA account is yours to keep – the money you save will roll over year to year.

Here are Ten Things to Know about HSAs:

1. A health savings account is a personal account you can use to save money for eligible medical, medication, dental and vision expenses. Please keep in mind that there are limits to the amount of money that may be contributed to an HSA on a yearly basis - those limits are described in other documents during open enrollment.

You won't pay taxes as long as you use the money for eligible medical, dental, vision and prescription drug expenses (as allowed by the option(s) you elect)

2. There's no deadline to spend the money in your HSA account because the balance carries over from year to year. The money is yours to keep whether you change medical plans, leave TLC or retire. This means that the money in your HSA rolls over each year. So, you can use it to pay for eligible expenses now or save it for later down the road—even all the way into retirement.

3. You can start, stop or change your contribution amount anytime throughout the year with KeyBank.

4. You can set an annual contribution amount with KeyBank - your initial enrollment and each open enrollment period. To do this, follow steps outlined in other open enrollment materials to ensure your account is opened and available for use. You can activate your health savings account on https://www.eenroller.net/btrac/site.asp?PPVS=TLCN1888 portal and using the TLC HSA hyperlink to KeyBank. The amount you set is generally split equally between pay periods and deducted before taxes from your paychecks throughout the year. Although you can start, stop or change your contribution amount anytime by properly completing and submitting a HAS Account Change form and submitting it to Human Resources.

5. You need to agree to the terms & conditions required by KeyBank when setting your contribution amount. You only need to do this once, not every year. If you can't agree to the terms & conditions required by KeyBank, call please contact Human Resources, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118

6. You need to activate your account to begin contributions and use or invest your funds. You only need to activate your account once with KeyBank (on Benetrac using the TLC HSA hyperlink to KeyBank), not every year if you stay in an applicable program sponsored by TLC.

7. If done correctly, you will get three tax breaks by using the HSA:

   -A lower taxable income when you make before-tax or tax-deductible contributions to your account.* That's right. The money you contribute from your paychecks goes into your account tax-free. Keep in mind, the IRS does limit how much you can contribute to this account each year. Any contributions from your employer count towards the IRS limits.

   - Tax-free withdrawals for eligible medical, medication, dental and vision expenses.

   -Tax-free earnings from interest and investments on amounts in your health savings account.* think of the HSA being similar to a 401(k) for healthcare. You also have the opportunity to invest money from your account. And you won't pay taxes on any earnings or interest. Investing your HSA dollars could earn you a greater return, and that could mean more financial security when it comes to covering healthcare costs in the future. You may need a certain balance before investing based on your vendor.

8. TLC has the ability contribute to your account, but only if that is part of your program for that year in question. If TLC is contributing to your account, it will be disclosed to you in the open enrollment materials.

9. You can only contribute to your HSA up to the IRS limit each year (and anything TLC contributes to your account counts toward the limit). The amount imposed on the HSA by TLC is included in your open enrollment materials.

10. With an HSA, you can invest the money in your health savings account. Contact KeyBank for the investment options that they may provide (e.g., you could inquire if they make investments such as stocks, bonds, treasury notes, money market accounts and mutual funds, etc.).

* Some states subject contributions, interest, dividends and capital gains to state taxes. Check with your tax advisor to see how your account is affected.

What Happens If I Leave TLC and/or Go On COBRA? The money in your health savings account is yours to keep. And, as long as you continue your HSA coverage through COBRA or continue other qualified HDHP coverage, you remain eligible to contribute to your health savings account.

Don't Forget to Activate Your HSA Account If You Haven't Already

This is important because expenses incurred before your health savings account is funded aren't eligible for reimbursement from your health savings account. Follow steps outlined in other open enrollment materials to ensure your account is opened and available for use.

Consider How to Manage Your Health Savings Account

Contributing to a health savings account can help you pay current medical expenses and even help you grow a healthcare nest egg for expenses in retirement. Here are things to consider to keep saving year after year.

1. Set a Contribution Amount each year on the KeyBank platform (available through our online website (via www.key.com/hsa. After choosing a health savings, decide how much to save in your account for the year. The contribution amount you set it split equally between your pay periods and deducted before taxes from your paychecks throughout the year. Remember, any employer contributions (not always applicable) to your health savings account apply toward the IRS annual limit. Although you can start, stop, or change your health savings account contribution amount anytime throughout the year, it's a good idea to set it during open enrollment so you can stretch out your contributions over the entire year.

2. Manage your account at KeyBank available through our online enrollment website (via http://www.paychexflex.com) via or on your vendor's platform. Also, don't forget to log-in and periodically to see your current balance, claims, investment returns and more.

3. Read IRS Publication 969 or Form 8889 at www.irs.gov/pub/irs-pdf/p969.pdf for more information about health savings account limits or contact your tax advisor.

OTC / Health Savings Account: Over the counter medications can now be reimbursed from your health savings account (as applicable under Plan terms). This may be available because under the Federal CARES Act, over-the-counter medications and products without a prescription purchased to treat personal injuries or sickness can now be reimbursed from your health savings account or health flexible spending account (as applicable under Plan terms).

OTC / Health Flexible Spending Account: Over the Counter Products (OTC) The limitations on OTC products stated in the SPD and Plan Document are removed. As allowed by applicable guidance, OTC products no longer require a

prescription and can be reimbursed under your plan. OTC products must be for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. OTC products that are beneficial to an individual's general health are not covered unless they are determined by a physician to be necessary to treat or alleviate a specific physical or mental illness. Amounts paid for menstrual care products shall be treated as paid for medical care. The changes described above are effective for amounts paid on or after January 1, 2020 and continue in force until amended by the Employer.

The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable).

Your Rights and Protections Against Surprise Medical Bills

This notice is provided for informational purposes and is only applicable to plans/programs sponsored by TLC as and when legally required. Any notices provided by applicable entities (providers, administrators, etc.) will control based on the program involved, circumstances, etc.

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing in certain situations. In these cases, you should not be charged more than your plan's copayments, coinsurance, and/or deductible.

Here is more detail:

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that have not signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.
"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care-like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance filling for:

Emergency services: if you have an emergency medical condition and get emergency services from an out-of-network provider or hospital/facility, the most they can bill you is your plans in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **cannot** be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services. If your insurance ID card says (and only if your insurance card says) "fully insured coverage," you **cannot** give written consent and give up your protections not to be balance billed for post-stabilization services.

Certain Services at an in-network hospital or ambulatory surgical center: When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plans in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balanced billed.

If you get other types of services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections. If your insurance ID card says "fully insured coverage," you **can't** give up your protections for these other services if they are a surprise bill. Surprise bills are when you're at an in-network hospital or ambulatory surgical facility and a participating doctor was not available, a non-participating doctor provided services without your knowledge, or unforeseen medical services were provided.

Services referred by your in-network doctor: If your insurance ID card sys "fully insured coverage," surprise bills include when your in-network doctor refers you to an out-of-network provider without your consent (including lab and pathology services). These providers **can't** balance bill you and may **not** ask you to give up protections not to be balance billed. You may need to sign a form (available on the Department of Financial Services' website) for the full balance billing protection to apply.

You are <u>never</u> required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.
-You are only responsible for paying your share of the cost (like copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out of network providers and facilities directly as applicable and required by law.

<u>-Generally, your health plan must:</u>
-cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- cover emergency services by out-of-network providers.
-base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
-count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you have been wrongly billed, and your coverage is subject to New York law ("fully insured coverage"), contact the New York State Department of Financial Services at (800) 342-3736 or suprisemedicalbills@dfs.ny.gov. Visit http://www.dfs.ny.gov for information about your rights under state law (if applicable to your arrangement).
In addition, or if your coverage is not “fully insured coverage”, you may contact the federal No Surprises Help Desk at 1 (800)-985-3059 for self-funded coverage or coverage bought outside New York. Visit http://www.cms.gov/nosurprises/consumers for information about your rights under federal law.

2023 Notation: Please be aware that the Plan is aware that Health and Human Services recently released an updated federal independent dispute resolution (IDR) process guidance document. The agency issued the guidance document for group health plans and insurers who are seeking to resolve a payment claim for items and services covered by the surprise billing protections under the No Surprises Act (NSA) of the Consolidated Appropriations Act, 2021 (CAA, 2021).

The NSA provisions apply to both insured and self-funded group health plans and are effective for plan years beginning on or after January 1, 2022. The NSA provisions protect participants from surprise bills for out-of-network (OON) emergency and air ambulance services, as well as certain OON services received at in-network

facilities. The NSA limits participant cost-sharing for covered OON services, leaving plans and insurers to address the balance of the bill from an OON provider or facility. In states with an applicable All-Payer Model Agreement or specified state law (which generally applies to fully insured plans), the OON provider rate is determined by the All-Payer Model Agreement or state law. Otherwise, if a plan or insurer and provider cannot agree on the OON payment amount after a 30-day negotiation period, then either party can initiate the federal IDR process.

The guidance document follows the issuance of final rules in August of 2022 regarding the NSA surprise billing requirements and federal IDR process. The final rules modified prior guidance on the federal IDR process after a Texas court found the prior guidance inconsistent with the CAA, 2021 statutory language.

Under the final rules, the arbitrator in the federal IDR process (termed the "certified IDR entity") must select the offer of the disputing party that best represents the value of the OON item or service under dispute after considering the qualifying payment amount, which is the median contracted rate for the item or service in the geographic region, as well as all permissible additional information submitted by the parties. Such additional information may include, for example, the level of training, experience, and quality and outcomes measurements of the provider, or the complexity of providing the service to the participant. The final rules also require certified IDR entities to explain their payment determinations and underlying rationale in a written decision submitted to the parties.

Accordingly, the guidance document provides detailed information about the federal IDR process that incorporates these changes from the final rules. The IDR process is conducted through the federal portal designed for this purpose. The guidance document explains the specific steps in the process, such as how the disputing parties engage in open negotiation prior to the federal IDR process, initiate the federal IDR process, and select a certified IDR entity. This information is summarized in helpful charts that include the applicable timeframes for each step and links to required notices. Instructions are also provided regarding submissions of offers and IDR fee payments, among other items.

NEW YORK STATE NO SURPRISE BILLING INFORMATION:

New York State's Department of Financial Services (NYDFS) has provided additional detailed information concerning New York State and the No Surprise Billing Requirements.

Here are some of the topics covered (please note this is an outline of topics and information provided by NYSDFS at https://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills - please visit that web page for more details, links, etc. concerning this topic):

- How to Protect Yourself from a Surprise Medical Bill If You Have Health Insurance Coverage Subject To NY Law – (your health insurance ID card says "fully insured")

- How to Protect Yourself from A Surprise Medical Bill If You Have Employer/Union Self-Funded Coverage (your health insurance ID card says "self-funded" or does not say "fully insured")

- How to Protect Yourself from A Surprise Medical Bill If You Are Uninsured / Good Faith Estimate for Uninsured or Self-Pay Patients

- How To Protect Yourself from A Surprise Medical Bill If You Have Employer/Union Self-Funded Coverage (your health insurance ID card says “self-funded” or does not say “fully insured”)
- How to Protect Yourself from A Surprise Medical Bill If You Are Uninsured
- Good Faith Estimate for Uninsured or Self-Pay Patients
- Patient-Provider Dispute Resolution Process for Good Faith Estimates
- NYS Patient-Provider Dispute Resolution Process If You Don’t Get a Good Faith Estimate
- Information Your Doctor and Other Health Care Professionals Must Give You
- Information Your Hospital Must Give You
- Emergency Services - How to Protect Yourself If You Have Health Insurance Coverage Subject to NY Law (your health insurance ID card says “fully insured”)
- Emergency Services - How to Protect Yourself If You Have Employer/Union Self-Funded Coverage (your health insurance ID card says “self-funded” or does not say “fully insured”)
- Emergency Services - How to Protect Yourself If You Are Uninsured
- Review Of Disputes by Independent Dispute Resolution Entity (IDRE)
- Payment For Independent Dispute Resolution (IDR)
- Questions About IDR

If you have questions about IDR, or need help completing an application, call (800) 342-3736 or email IDRquestions@dfs.ny.gov. Where applicable, please indicate the date(s) of service in your inquiry as different laws and processes may apply depending on when you received the services

- Consumer Questions and Complaints

  File a Complaint: https://www.dfs.ny.gov/complaint

  How to Contact NYS DFS if you have questions & office locations:
  https://www.dfs.ny.gov/contact_us/main

Discrimination and Harassment Protections

Federal, state, and some local laws protect workers from discrimination or harassment based on certain protected characteristics. New York State law protects workers in certain protected classes such as age, race, creed, color, hairstyles associated with race, national origin, sex, sexual orientation, sexual harassment, pregnancy, pregnancy-related conditions, Sabbath observance or religious practices, gender identity or expression, disability, military status, predisposing genetic characteristics, familial status, marital status, domestic violence victim status, or prior arrest record or conviction record.

New York State has strengthened protections against discrimination and harassment, including sexual harassment, in the New York State Human Rights Law. The legislation strengthened New York's anti-discrimination laws to ensure employees can seek justice and perpetrators will be held accountable by eliminating the restriction that harassment be "severe or pervasive" in order to be legally actionable; mandating that all non-disclosure agreements allow employees to file a complaint of harassment or discrimination; and extending the statute of limitations for employment sexual harassment claims filed from one year to three years.

Protected Classes/Categories under the New York law are age, race, creed, color, hairstyles associated with race, national origin, sex, sexual orientation, sexual harassment, pregnancy, pregnancy-related conditions, Sabbath observance or religious practices, gender identity or expression, disability, military status, predisposing genetic characteristics, familial status, marital status, domestic violence victim status, or prior arrest record or conviction record (as well as any other category under applicable laws.

On March 16, 2022, New York Governor Hochul signed into law several amendments to the New York State Human Rights Law (NYSHRL) that became effective on that date.

One modification made by this law aims to prohibit retaliation through the publication of an employee's personnel records. The amendment modifies the definition of "unlawful retaliation" to include "disclosing an employee's personnel files because he or she has opposed any practices forbidden [under the NYSHRL] or because he or she has filed a complaint, testified, or assisted in any proceeding." The amendment still allows employers to disclose personnel information "where such release is necessary to respond to a complaint, civil or criminal action, or judicial or administrative proceeding." Additional information regarding this amendment can be found at: https://www.nysenate.gov/legislation/bills/2021/a7101

There are many more specifics and provisions. Please contact Human Resources if you have any questions and/or concerns.

New York State Sexual Harassment

This provision will incorporate and update as required for applicable New York State laws

New York law has established minimum standards for sexual harassment prevention policies and training. Your employer is required to distribute their policy, in writing, to you and every other employee in your organization. They are also required to provide you with an interactive training about sexual harassment prevention.

If you believe that you have been subjected to sexual harassment, you are encouraged to complete your employer's Complaint Form and submit it to the person or office designated by your employer. If you are more comfortable reporting verbally or in another manner, your employer should still complete the complaint form, provide you with a copy and follow its sexual harassment prevention policy by investigating the claims. More information is available at: https://www.ny.gov/programs/combating-sexual-harassment-workplace

There are many more specifics and provisions. The hotline providing counsel and assistance to individuals with complaints of workplace sexual harassment is now available. The telephone number for the hotline is 1-800-HARASS-3 (1-800-427-2773). Employers should include information about the hotline in the materials that they provide to employees regarding sexual harassment.

Sexual harassment is against the law.

All employees have a legal right to a workplace free from sexual harassment, and TL Cannon is committed to maintaining a workplace free from sexual harassment.

Per New York State Law, TL CANNON, Inc. has a sexual harassment prevention policy in place that protects you. This policy applies to all employees, paid or unpaid interns and non-employees in our workplace, regardless of immigration status.

If you believe you have been subjected to or witnessed sexual harassment, you are encouraged to report the harassment to a supervisor, manager or [other person designated] so we can take action.

Our complete policy may be obtained at: www.tlcannon.com
By calling 716/634-7700
By asking a Manager
Through the US Mail
Human Resources
180 Lawrence Bell-Suite 100
Williamsville, NY 14221

Our Complaint Form may be obtained at: www.tlcannon.com
By calling 716/634-7700
By asking a Manager
Through the US Mail
Human Resources
180 Lawrence Bell-Suite 100
Williamsville, NY 14221

If you have questions and to make a complaint, please contact:
Human Resources, 180 Lawrence Bell, Suite 100, Williamsville, NY 14221
716/634-7700

For more information and additional resources, please visit: **www.ny.gov/programs/combating-sexual-harassment-workplace**

New York State Pay Equity Laws

To the extent applicable to benefit programs/arrangements (if at all) and only as required, TLC will abide by the revisions to New York pay equity laws. New York's Pay Equity Law was recently enacted to protect equity in pay. One of the most important aspects of the law that bans salary history inquiries, which took effect on January 6, 2020, is that New York employers cannot ask job applicants to provide their wage or salary history as a condition of employment. In addition, current employees do not have to provide their salary history from any outside employers. The law also prevents businesses from seeking similar information from other sources.

New York State Whistleblower

Notice of Employee Rights, Protections, and Obligations, Under Labor Law Section 740
Prohibited Retaliatory Personnel Action by Employers, § 740. Retaliatory action by employers; prohibition.

1. Definitions. For purposes of this section, unless the context specifically indicates otherwise:

(a) "Employee" means an individual who performs services for and under the control and direction of an employer for wages or other remuneration, including former employees, or natural persons employed as independent contractors to carry out work in furtherance of an employer's business enterprise who are not themselves employers.

(b) "Employer" means any person, firm, partnership, institution, corporation, or association that employs one or more employees.

(c) "Law, rule or regulation" includes: (i) any duly enacted federal, state or local statute or ordinance or executive order; (ii) any rule or regulation promulgated pursuant to such statute or ordinance or executive order; or (iii) any judicial or administrative decision, ruling or order.

(d) "Public body" includes the following:

(i) the United States Congress, any state legislature, or any elected local governmental body, or any member or employee thereof;

(ii) any federal, state, or local court, or any member or employee thereof, or any grand or petit jury;

(iii) any federal, state, or local regulatory, administrative, or public agency or authority, or instrumentality thereof;

(iv) any federal, state, or local law enforcement agency, prosecutorial office, or police or peace officer;
(v) any federal, state or local department of an executive branch of government; or

(vi) any division, board, bureau, office, committee, or commission of any of the public bodies described in subparagraphs (i) through (v) of this paragraph.

(e) "Retaliatory action" means an adverse action taken by an employer or his or her agent to discharge, threaten, penalize, or in any other manner discriminate against any employee or former employee exercising his or her rights under this section, including (i) adverse employment actions or threats to take such adverse employment actions against an employee in the terms of conditions of employment including but not limited to discharge, suspension, or demotion; (ii) actions or threats to take such actions that would adversely impact a former employee's current or future employment; or (iii) threatening to contact or contacting United States immigration authorities or otherwise reporting or threatening to report an employee's suspected citizenship or immigration status or the suspected citizenship or immigration status of an employee's family or household member, as defined in subdivision two of section four hundred fifty-nine-a of the social services law, to a federal, state, or local agency.

(f) "Supervisor" means any individual within an employer's organization who has the authority to direct and control the work performance of the affected employee; or who has managerial authority to take corrective action regarding the violation of the law, rule or regulation of which the employee complains.

2. Prohibitions. An employer shall not take any retaliatory action against an employee, whether or not within the scope of the employee's job duties, because such employee does any of the following:

(a) discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that the employee reasonably believes is in violation of law, rule or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety;

(b) provides information to, or testifies before, any public body conducting an investigation, hearing

or inquiry into any such activity, policy or practice by such employer; or

(c) objects to, or refuses to participate in any such activity, policy or practice.

3. Application. The protection against retaliatory action provided by paragraph (a) of subdivision two of this section pertaining to disclosure to a public body shall not apply to an employee who makes such disclosure to a public body unless the employee has made a good faith effort to notify his or her employer by bringing the activity, policy or practice to the attention of a supervisor of the employer and has afforded such employer a reasonable opportunity to correct such activity, policy or practice. Such employer notification shall not be required where:

(a) there is an imminent and serious danger to the public health or safety;

(b) the employee reasonably believes that reporting to the supervisor would result in a destruction of evidence or other concealment of the activity, policy or practice;

(c) such activity, policy or practice could reasonably be expected to lead to endangering the welfare of a minor;

(d) the employee reasonably believes that reporting to the supervisor would result in physical harm to the employee or any other person; or

(e) the employee reasonably believes that the supervisor is already aware of the activity, policy or practice and will not correct such activity, policy or practice.

4. Violation; remedy.

(a) An employee who has been the subject of a retaliatory action in violation of this section may institute a civil action in a court of competent jurisdiction for relief as set forth in subdivision five of this section within two years after the alleged retaliatory action was taken.

(b) Any action authorized by this section may be brought in the county in which the alleged retaliatory action occurred, in the county in which the complainant resides, or in the county in which the employer has its principal place of business. In any such action, the parties shall be entitled to a jury trial.

(c) It shall be a defense to any action brought pursuant to this section that the retaliatory action was predicated upon grounds other than the employee's exercise of any rights protected by this section.

5. Relief. In any action brought pursuant to subdivision four of this section, the court may order relief as follows:

(a) an injunction to restrain continued violation of this section;

(b) the reinstatement of the employee to the same position held before the retaliatory action, or to an equivalent position, or front pay in lieu thereof;

(c) the reinstatement of full fringe benefits and seniority rights;

(d) the compensation for lost wages, benefits and other remuneration;

(e) the payment by the employer of reasonable costs, disbursements, and attorney's fees;

(f) a civil penalty of an amount not to exceed ten thousand dollars; and/or

(g) the payment by the employer of punitive damages, if the violation was willful, malicious or wanton.

6. Employer relief. A court, in its discretion, may also order that reasonable attorneys' fees and court costs and disbursements be awarded to an employer if the court determines that an action brought by an employee under this section was without basis in law or in fact.

7. Existing rights. Nothing in this section shall be deemed to diminish the rights, privileges, or remedies of any employee under any other law or regulation or under any collective bargaining agreement or employment contract.

8. Publication. Every employer shall inform employees of their protections, rights and obligations under this section, by posting a notice thereof. Such notices shall be posted conspicuously in easily accessible and well-lighted places customarily frequented by employees and applicants for employment.

HSA Certification

If you wish to participate in a health savings account program sponsored by TLC, you may be required to complete a Certification for the health savings account confirming your eligibility and that you have meet all requirements. Once all requirements are met to participate in a health savings account program sponsored by TLC. If you are requested to completed a certification, please submit it to the Human Resources Department.

Family and Medical Leave Requirements

Under this Federal law, eligible employees may take up to 12 weeks of unpaid leave each year because of the birth of a child or the placement of a child for adoption or foster care, to care for an immediate family member who has a serious health condition, or because of their own serious health condition.

Plan coverage will be maintained for an employee on FMLA leave on the same terms and conditions as if the employee had continued to work to the extent required by the FMLA, and as described in the applicable employee handbook. To continue Plan coverage during FMLA, an employee must pay the employee premium as described and required in the Supporting Documents. For additional information on FMLA, contact the Plan Administrator.

Coverage during an FMLA leave of absence will be administered in accordance with the policies established by the employer and applicable law including the following: (a) during an FMLA leave of absence, coverage under this Plan shall be maintained on the same terms and conditions as the coverage that would have been provided had the Covered Employee not taken the FMLA leave (including any Employee contribution requirement); and (b) if Plan coverage lapses during the FMLA leave, coverage will be reinstated upon the employee's return to work at the conclusion of the FMLA leave, but only for the person(s) who had coverage under the Plan when the FMLA leave began. It is the intention of the Employer to provide FMLA benefits only to the extent required by applicable law and not to confer greater rights than those required by law on any Covered Individual.

For more information about your rights under the FMLA, how it may or may not impact your benefits, or leaves generally, contact the Human Resources Department.

The United States Department of Labor is authorized to investigate and resolve complaints of violations. An eligible employee may bring a civil action against an employer for violations. The FMLA does not affect any Federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights.

USERRA Leaves: If an employee is absent from work because of eligible active military services, the employee has the right under Federal law to continue certain Plan coverage for up to 24 months. For more information, contact the Plan Administrator.

Additional Military Leave Requirements: Under other Federal and state law, special rules apply to an employee on military leave and his or her eligible dependents. The Plan will comply with applicable Federal and state laws. For more information, Human Resources can provide you with more detailed information on how these rules work.

Other Leaves of Absence: If an employee takes any other leave of absence or is absent from work for any reason other than FMLA, New York State Paid Family Leave, USERRA leave, paid time-off, or approved unpaid personal leave, applicable Plan coverage will end on the last day of the month for all coverages except life insurance. Life insurance ends on the employee's last day of work. Proper election of COBRA may impact certain medical coverages.

What Circumstances May Impact Benefits?

Your benefits (and the benefits of your eligible family members) will cease when your participation in the plans and/or programs sponsored by TL Cannon (including any component plans/programs) terminates.

However, other circumstances can result in termination, reduction, denial, or loss of benefits. The plans and/or programs sponsored by TL Cannon may also have the right to recover overpaid benefits and to seek subrogation and/or reimbursement in certain circumstances and with respect to certain benefit plans and/or programs. The applicable insurance contracts (including the certificate of insurance booklets), plans, and other governing documents provide additional information about termination, denial, or loss of benefits, an about the recovery, subrogation, and reimbursement rights under the plans/programs sponsored by TL Cannon.

The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable). See the next Section entitled "Circumstances that May Result in the Denial or Loss of Benefits"

Right to Information & Circumstances that may Result in the Denial or Loss of Benefits

In General: Various circumstances may result in the termination, reduction, denial, or loss of Plan benefits. Some of these circumstances are described herein and others are described in the Supporting Documents. For additional information, refer to the Supporting Documents.

Coordination of Benefits: When a participant is also covered under another group health plan or policy, this plan will coordinate benefit payments with any payments made under the other plan or policy as provided in the Supporting Documents. One plan or policy will pay the benefits as a primary benefit. The other plan or policy will pay secondary benefits, to the level covered by that plan or policy, if necessary to cover the participant's expenses. The coordination of benefits rules in this Plan and the other plan or policy will determine which plan or policy is primary. The Supporting Documents state the coordination of benefit rules for health and dental benefits under this Plan.

Subrogation and Reimbursement: If a 3rd party is responsible for any injury or illness covered by the Plan, the Plan has the right to all or part of any amount that the participant or another person recovers or might recover from the third party. For more information, referred to the Supporting Documents to this Plan.

Fraudulent Claims Any person claiming benefits under the Plan shall furnish the insurer and/or Plan with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan. The Plan Administrator and the insurer shall have the right and opportunity to have a participant examined when benefits are claimed, and when and so often as it may be required during the pendency of any claim under the Plan.

If a person is found to have falsified any document in support of coverage or a claim for benefits under the Plan, or failed to have corrected information which such person knows or should have known to be incorrect or failed to bring such misinformation to the attention of the Plan Administrator or insurer, the Plan Administrator may, without the consent of any person and to the fullest extent permitted by applicable law(s), terminate the person's Plan coverage, including retroactively (such as in situations involving fraud or material misstatement of fact). In addition, the insurer may refuse to honor any claim for benefits under the Plan for the participant related to the person submitting the falsified information (as determined in the Plan Administrator's sole discretion).

Right to Recover Overpayments and Other Erroneous Payments: If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount that was properly payable under the Plan to a participant, the participant shall be responsible for repaying the overpayment to the Plan to the fullest extent allowed by applicable law and Plan requirements. The Plan reserves the right to be made whole without offsets for attorney's fees, to the extent permitted by law and Plan requirements. Further, if the Plan makes any payment that, according to the terms of the Plan and/or the applicable Supporting Documents should have been made, the insurer, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law and Plan requirements, recover that incorrect payment, whether or not it was made due to the insurer's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

As permitted in the sole discretion of the Plan Administrator or insurer, the refund or repayment may be made in any one or more of the following methods (1) a simple lump sum payment, (2) a reduction in future benefit payments otherwise payable under the plan, (3) automatic deductions from the payroll of the employee for the benefit of the employee, or (4) any other method designated by the Plan Administrator, administrator, and/or applicable service provider in its sole discretion. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Rights Against the Plan Sponsor, Employer / No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between any individual and TLC (or any of its related entities) to the effect that the individual will be employed for any specific period of time. Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the employer. The Plan, including the component benefit plans and/or programs, is not intended to e, and may not be construed as constituting, a contract or other arrangement between you and TL Cannon (or any TL Cannon entity) for employment.

Certificates of Creditable Coverage Due to Pre-Existing Condition Exclusions

In the past, employer-sponsored group health plans have been required to provide individuals who lose their coverage (or would lose it if they didn't get continuing coverage through COBRA) with a Certificate of Creditable Coverage. A certificate of creditable coverage (COCC) is a document provided by your prior insurer that indicates your insurance has ended. The document itself includes your full name, effective dates of coverage, and the cancellation date. The COCC was created under the Health Insurance Portability and Accountability Act (HIPAA), which ensures that those who want to change health insurance carriers can do so without having a gap in medical insurance. Such a document applies when a person joins a new company and wishes to enroll in the employer-sponsored health insurance plan. Without HIPAA, those people enrolling in the new coverage may have to wait a period of time before enrolling, which would mean that the prior health insurance plan would end before the new one begins. However, under HIPAA laws, such gap is not allowed.

The federal law regarding COCC is different from that of state laws, which are implemented to address the underlying issues regarding takeover benefits and the eligibility requirements for obtaining health insurance. While the federal law may trump state laws if any conflicts in the rules arise, the states have complete control over health insurance plans within their jurisdiction. For example, some states do not recognize COCC from someone's health insurance as a valid entry into a state-sponsored high-risk health insurance plan. Further, in certain situations states are allowed to impose additional requirements as long as they are above and beyond what is required by the Federal law.

A new regulation on Exchange and Insurance Market Standards for 2015 and Beyond published by the U.S. Department of Health and Human Services (HHS) confirms that certain states can terminate the issuance of the COCC and even allow those with pre-existing health conditions to obtain insurance more easily. Therefore, as of January 1, 2015, most health insurance plans no longer contain pre-existing conditions, particularly due to the implementation of the Patient Protection and Affordable Care Act (ACA).

The main purpose of providing the COCC was to protect employees who change to a new plan and need proof of prior coverage. With the regulation eliminating the COCC, it allows those employees to further reduce any waiting periods, health exclusions, and other pre-existing condition exclusions that could prevent those from obtaining health insurance with a different insurance carrier. With that being said, however, some health insurance policies still contain pre-existing condition exclusions that could prevent those falling into this category from obtaining coverage.

More specifically, although Certificates of Creditable Coverage appear obsolete, it is still necessary, in certain circumstances, to document the dates of creditable coverage – For example COBRA/continuation coverage early termination notices.

For individuals who leave a company and lose their health coverage, COBRA/continuation coverage is generally available for a maximum period up to 18, 29, or 36 months. But group health plans are allowed terminate that coverage early under certain circumstances, including situations were (a) payments not made timely, (b) qualified beneficiary begins coverage under another group health plan after electing COBRA/continuation coverage, (c) a qualified beneficiary becomes entitled to Medicare benefits after electing COBRA/continuation coverage, (d) a qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving COBRA/continuation coverage, such as submitting a fraudulent claim, etc.

As an example , if COBRA/continuation coverage is terminated early, the plan administrator may be required to give the qualified beneficiary a Notice of Early Termination of Continuation Coverage as soon as practicable following the decision to terminate COBRA coverage. As per the example, a former employee on COBRA/continuation coverage or a new hire that's been on COBRA/continuation coverage and is now signing on to your group health plan, the individual needs documentation of when their previous coverage ended.

Title VII

Title VII prohibits employers from discriminating against employees with respect to compensation, terms, conditions, or privileges of employment on the basis of race, color, religion, sex, or national origin. The United States Supreme Court recently held in Bostock v. Clayton County Georgia that the term "sex" under Title VII includes sexual orientation and gender identity. New York state law also provides protections as described in those sections.

NYS Paid Sick Leave

On April 3, 2020, legislation was signed establishing the right to paid leave for New Yorkers. New York's paid sick leave law requires employers with five or more employees or net income of more than $1 million to provide paid sick leave to employees and for employers with fewer than five employees and a net income of $1 million or less to provide unpaid sick leave to employees. This new law is in addition to the New York State provisions already in effect providing emergency paid sick time due to COVID-19.

On September 30, 2020, covered employees in New York State began to accrue leave at a rate of one hour for every 30 hours worked. On January 1, 2021, employees were able to start using accrued leave.

For more information on the amount of leave, accruals, eligibility, and permitted uses: https://www.ny.gov/new-york-paid-sick-leave/new-york-paid-sick-leave#amount-of-leave
and for FAQs visit: https://www.ny.gov/sites/default/files/atoms/files/PSL_FAQ_PaidSickLeaveFAQ.pdf.

New York State Paid Family Leave

Many employees of private employers in New York State will be eligible for Paid Family Leave. Employees must be employed by a covered employer at the time they apply for Paid Family Leave and meet several other employee eligibility requirements that will be explained in a separate notice.

Covered employees become eligible to take Paid Family Leave for a qualifying event once they have met the minimum time-worked requirements as implemented by your employer:

A. Full-time employees: Employees who work a regular schedule of 20 or more hours per week are eligible after 26 consecutive weeks of employment.

B. Part-time employees: Employees who work a regular schedule of less than 20 hours per week are eligible after working 175 days, which do not need to be consecutive. Employees with irregular schedules should look at their average schedule to determine if they work, on average, fewer than 20 hours per week.

The use of scheduled vacation time; the use of personal, sick or other time away from work that has been approved by the employer; or other periods where the employee is away from work but is still considered to be an employee by the employer, shall be counted as consecutive weeks or consecutive work weeks, or days worked, as long as the contributions to the cost of family leave benefits have been paid for such periods of time. However, periods of statutory short-term disability do not count as consecutive weeks or days worked for determining eligibility.

Once employees meet the eligibility requirements, they remain eligible for that employer until employment is terminated. If employees start a new job, they generally must work long enough with their new employer to meet the eligibility requirement. Citizenship and/or immigration status is not a factor in employee eligibility.

Once an employee is eligible, leave is provided for certain events such as Bonding (birth of a child, adoption, foster care); family care, military family support

For more information:

A. General: https://paidfamilyleave.ny.gov/employees

B. Benefits Schedule: https://paidfamilyleave.ny.gov/benefits

Can You Opt Out? Paid Family Leave is not optional for eligible employees. Coverage can only be waived if:

A. You regularly work 20 hours or more per week, but you won't be in employment with that employer for 26 consecutive weeks; or

B. You regularly work fewer than 20 hours per week and you will not work 175 days in a 52-week period.

Employers must offer a waiver to employees who qualify for one. If you waive coverage, you will not make contributions and will not be eligible for Paid Family Leave benefits.

2023 Out-of-Pocket Maximums

An out-of-pocket maximum (OOP maximum) is generally the most you have to pay per year for covered healthcare services (depending on plan terms, specifics, coverage options, networks, etc.). When you have spent this amount in your plan year on defined deductibles, copayments, and coinsurance for in-network care and services, your health insurer will pay for 100% of your healthcare services.

The intent of the OOP maximums is to help individuals and families avoid major financial problems associated with high healthcare costs in years when they need a lot of treatment. There are some exceptions, though, so make sure you understand what is and isn't covered. Otherwise, you may end up with a nasty surprise.

Over time, the amounts you pay toward your care are applied toward your OOP max. Sometimes (depending on your program), your plan may also pay a portion of your costs during this time (for example, if you have met your deductible). Once you have met your OOP max, your plan will pay all of your covered costs until your OOP max resets. Generally speaking, you OOP max resets whenever you change or renew your plan. That means it starts at zero when you get a new plan or at the beginning of a plan/benefit coverage year.

Also, there are some things that are not counted toward your OOP maximum, such as insurance and/or coverage premiums, anything you spend for services your plan doesn't cover, certain out-of-network care and services (again, depending on Plan terms), costs above the allowed amount for a service that a provider may charge, etc.

These exceptions mean that even when you reach your out-of-pocket maximum for the year, you will still have to pay your premiums to stay covered. You should also be careful to use in-network healthcare providers if you want to control the costs of your healthcare, because out-of-network costs don't count toward your out-of-pocket maximum.

Also, costs that aren't considered covered expenses don't count toward the out-of-pocket maximum. For example, if a covered person pays $2,000 for an elective surgery that isn't covered, that amount will not count toward the maximum. This means that you could end up paying more than the out-of-pocket limit in a given year.

Another thing to keep in mind is that group health plans with a family out-of-pocket maximum that is higher than the ACA's self-only out-of-pocket maximum limit must embed an individual out-of-pocket maximum in family coverage so that no individual's out-of-pocket expenses exceed that limit

The highest out-of-pocket maximum you will have to pay is controlled by federal law. The government has set limits that control how much healthcare insurers can charge for covered services per year. The Plan has provided this limit to you via a separate notice and/or SBCs.

Here is a quick example – This is just an example. The amounts used (deductibles, OOP max, etc.) are not actual plan limits for your plan in 2021 (see SBCs and plan documentation for your limits for 2021). By way of example, suppose you need covered care that costs $20,000. If your plan has a $1,300 deductible, you would then be responsible for 20% of the cost of care after that. If your OOP max is at $4400, how much would you play? First, you'd pay your $1,300 deductible. Then, you'd pay 20% of the remaining $18,700 which would be $$3,740; however, because your OOP max is only $4,400, you would not have to pay the full amount $5,040. Instead, you'd pay only $4,400 including your deductible and part of your 20%, and that's it. If you'd already met all of part of your deductible and OOP max, you'd pay even less in this scenario.

The OOP maximum will not exceed applicable limitations as explained in the summaries of benefits and coverage (SBCs) and any applicable Plan documentation, supporting documents, SBCs, in your open enrollment materials, the Summary Plan Description (SPD), and any applicable Summary of Material Modification to the applicable SPD (including any applicable embedded limits). If you have any questions or concerns, you may contact the plan administrator at T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

Amendment and Termination

As the settlor of the Plan, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part. This includes amending the benefits under the Plan. Because amendments are made by the Plan Sponsor in its settlor capacity (and not as Plan Administrator), they are not subject to ERISA's fiduciary standards. The procedure for amending the Plan is for the Plan Sponsor's Board of Directors (or its delegate) to adopt a resolution approving the amendment. However, the Plan Sponsor's Director of Employee Benefits has authority to adopt legal, technical, compliance, and administrative amendments to the Plan without the need for Board of Directors approval.

If the Plan is terminated, the rights of the covered individuals are limited to covered charges incurred before the Plan's termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for covered charges incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. To the extent that any Plan assets remain, they will be used for the benefit of covered individuals and employees in accordance with ERISA. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Your ERISA Rights

Note that this statement does not apply to any benefits that are not covered by ERISA. Accordingly, this statement would not apply to any benefits offered under those programs.

Discretionary Authority

The Plan Administrator has the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to

include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also has the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. The procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated, is contained in the Employer's Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. No consent of any participant is required to terminate, modify, amend or change the Plan.

Statement of Rights

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, 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 operations of the Plan, including but not limited to any insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case 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, your 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 (e.g., the Supporting Documents) on the rules governing your federal continuation coverage rights.

Historical Language Retained: Contact the Plan Administrator if you require a certificate of creditable coverage. Historical Language: **Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan.**

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so

prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored 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 (Form 5500), if any, 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 TLC, as plan administrator, to provide the materials and pay you up to $110 a day (as adjusted from time to time by the DOL, so this amount may increase) 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 which is denied or ignored, in whole or in part, and you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or 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.

COBRA Election and Payment Deadlines Extended to after the "Outbreak Period"

On April 29, 2020, the Department of Labor, Revenue, and Treasury (the "Departments") issued guidance extending certain timeframes for group health plans during the COVID-19 National Emergency. As background, on March 13, 2020, President Trump issued the Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak and by separate letter declared a national emergency under the Stafford Act effective March 1, 2020.

The guidance announced that plans, "must disregard the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency or such other date announced by the Agencies [Departments] in a future notice (the 'Outbreak Period') for all plan participants, beneficiaries, qualified beneficiaries, or claimants wherever located in determining the following periods and dates." Please note: The end of the National Emergency has not been determined at this time. If may happen during the 2023 Plan year/coverage year. The dates in the following examples are for illustration purposes only and should not be used for determining or calculating actual timeframe extensions.

Pursuant to this guidance the Employer amends the plan to extend the following timeframes:

COBRA Continuation Coverage. The Outbreak Period is disregarded in applying the time limits for an individual to notify the Plan of certain qualifying events, to elect COBRA continuation coverage and to timely pay the applicable COBRA premiums.

The following examples illustrate the application of the guidance to these COBRA time limits:

Notification of Certain Qualifying Events. The employee or ex-spouse must notify the Plan within 60 days of a divorce in order for the ex-spouse to be eligible to elect COBRA continuation coverage. The couple's judgment of divorce is entered on March 31, 2020. The 60-day notice period would otherwise end on May 30, 2020. However, if the Outbreak Period ends on July 30, 2020 (see above example), notice will be timely if provided by no later than September 28, 2020 (60 days after the Outbreak Period ends).

Electing COBRA. The employee experiences a qualifying event and is provided an election notice on February 23, 2020. The 60-day notice period would otherwise end on April 23, 2020. However, the Outbreak Period started on March 1, 2020 and if it ends on July 30, 2020 (see above example), the first 6 days of the 60-day election period occurred before the Outbreak Period began and the remaining 54 days occur after the Outbreak Period ends. As a result, the employee has until September 22, 2020 to timely elect COBRA continuation coverage.

COBRA Premium Payments. The employee experiences a qualifying event in 2019 and elects COBRA continuation coverage. Monthly payment for March, April, May and June 2020 is due on the first day of the applicable month, with a 30-day grace period for timely payment. The Outbreak Period began on March 1, 2020 and assuming it ends on July 30, 2020 (see above example), the employee has 30 days until after July 30, 2020 (August 29, 2020) to timely make the monthly premiums for these four months.

Again, please note: The end of the National Emergency has not been determined at this time. If may happen during the 2023 Plan year/coverage year. The dates in the following examples are for illustration purposes only and should not be used for determining or calculating actual timeframe extensions.

USERRA Notice

If you take a military leave under USERRA, whether for active duty or for training, you are entitled to continue coverage under the Plan during the USERRA leave for up to twenty-four (24) months as long as you give advance notice (with certain exceptions) of the leave. If the entire length of the leave is less than thirty-one (31) days, your contributions will remain the same as before the leave (to the extent such coverage continues to be offered under the Plan at the time of your return). If the entire length of the leave is thirty-one (31) days or longer, you may be required to pay up to 102 percent of the entire amount necessary to cover you, and your eligible dependent(s). Coverage under USERRA will run concurrently with any right to continue coverage under COBRA.

If your military leave lasts thirty-one (31) days or longer and you do not elect to continue coverage during the leave, your coverage will be reinstated upon reemployment on the same terms and conditions as existed prior to your military leave (to the extent such coverage continues to be available at the time of your reemployment). However, no exclusion or waiting period will be imposed upon you or your covered dependents upon reemployment except to the extent it would have been imposed if your coverage had not been terminated as a result of the military leave. This rule does not apply to the coverage of any illness or injury determined by the Secretary of Veterans' Affairs to have been incurred in, or aggravated during, performance of service in the uniformed service.

For more information on your rights under USERRA and military leave, a VETS directory and additional information is available at http://www.dol.gov/vets/

TLC OHCA HEALTH INFORMATION PRIVACY NOTICE

The TLC OHCA is committed to protecting the privacy and security of participants' health information and has undertaken efforts to comply with all applicable laws and regulations intended to protect the privacy and security of such information, including the privacy regulations of the Health Insurance and Portability Act of 1996 (HIPAA), as amended. If you have questions regarding the plan's privacy policies and procedures, please refer to the included TLC OHCA Notice of Privacy Practices. You can also read or print a paper copy of the notice on Benetrac at any time (http://www.paychexflex.com). If you are viewing this notice online and would like a printed copy, simply print from your web browser.

Please note that the Plan's privacy practices may be changed at any time at the Plan administrator's sole discretion. If any material revision is made to the Plan's Notice of Privacy Practices, the revised notice will be distributed in accordance with applicable law(s) and requirements.

HIPAA NOTICE OF PRIVACY PRACTICES From the TLC OHCA

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require that the TLC OHCA (defined below) periodically a reminder to participants about the availability of the TLC OHCA's privacy notice, to provide such notice and/or how to obtain that notice. The Privacy Notice generally explains participants rights and the TLC OHCA's legal duties with respect to protected health information/PHI (also defined below) and how the plan may use and disclose PHI.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

T.L. Cannon is committed to protection the privacy and security of participants' health information and has undertaken efforts to comply with all applicable laws and regulations intended to protect the privacy and security of such information, including the privacy regulations of the Health Information Portability and Accountability Act of 1996 (HIPAA), as amended. If you have questions regarding T.L. Cannon's privacy policies and procedures, please refer to the included Notice of Privacy Practices (below). The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable).

In case of a conflict between this HIPAA Notice and the TL Cannon HIPAA Policies & Procedures, the TL Cannon HIPAA Policies & Procedures will control.[3]

The applicable group health plans are required to provide this Notice to you pursuant to HIPAA. This HIPAA Notice summarizes how medical information about you may be used and disclosed in certain circumstances. In case of a conflict between this HIPAA Notice and the T.L. Cannon HIPAA Policies & Procedures, the T.L. Cannon HIPAA Policies & Procedures will be control.

[3] We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

TLC & Medical Information

We are committed to protecting your personal health information. We are required by law to (1) make sure that any medical information that identifies you is kept private; (2) provide you with certain rights with respect to your medical information; (3) give you a notice of our legal duties and privacy practices; and (4) follow all privacy practices and procedures currently in effect. The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable).

This Notice of Privacy Practices (the "Notice") describes the legal obligations of group health plans included in the TL Cannon sponsored group health programs participating in the T.L. Cannon OHCA[4] and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH Act), and other applicable laws (e.g., the New York State General Business Law Section 899-aa).

Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. Any reference to the "plan", "plans", "group health plan", "group health plans", "us," "we," or "our" in this Notice refers to the Covered Entities as described in this notice.

If you have any questions about this Notice or about our privacy practices, please contact T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

TLC is committed to protecting the privacy and security of participants' health information and has undertaken efforts to comply with all applicable laws and regulations intended to protect the privacy and security of such information, including the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended. If you have questions regarding het plan's privacy policies and procedures, please refer to the following Notice of Privacy Practices.

If you are viewing this notice online and you would like a printed copy, simply print from your web browser. If you received a printed copy, this notice is also available on Benetrac and/or from the Human Resources Department. The Plan's privacy practices may be changed at any time at the Plan administrator's sole discretion. If any material revision is made to the Plan's Notice of Privacy Practices, the revised notice will be distributed in accordance with applicable law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

[4] Covered entities that participate in an OHCA may use a single, joint notice that covers all of the participating covered entities (provided that the conditions at 45 CFR 164.520(d) are met), or may each maintain separate notices. Where a joint notice is provided (such as in this circumstance) to an individual by any one of the covered entities to which the joint notice applies, the Privacy Rule's requirements for providing the notice are satisfied for all others covered by the joint notice. Where the joint notice is provided to the individual by a participating covered entity other than a direct treatment provider, no acknowledgment of receipt need be obtained. The Plan interprets this notice to meet this requirement.

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

Definitions

The following terms appearing in this Notice have special meaning, as explained below:

Covered Entity: A Covered Entity is a health plan, a health care clearinghouse or a health care provider that transmits any health information in electronic form in connection with a transaction covered by the HIPAA Privacy Rule.

Designated Record Set: A Designated Record Set is a group of records maintained by or cared for a Covered Entity that is: (i) the medical records and billing records about individuals maintained by or for a covered health care provider; (ii) the enrollment, payment, claims adjudication, and case or medical management records systems maintained by or for a health plan; or (iii) used, in whole or part, by or for the Covered Entity to make decisions about individuals.

Effective Date

This Notice amends your prior Notice of Privacy Practices. This Notice is effective as revised January 1, 2023.

What is Protected Health Information?

Protected health information is individually identifiable health information that is maintained or transmitted by a Covered Entity, subject to some exceptions. Individually identifiable health information is health information: (i) that is created or received by a health care provider, health plan, employer or health care clearinghouse; and (ii) that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you; and (iii) with respect to which there is a reasonable basis for believing that the information can be used to identify you. Protected health information includes generic information such as family medical history and information about an individual's receipt of genetic services or genetic tests. However, protected health information does not include employment records held by TLC (or any related entity/entities) in its role as an employer.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;

- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised

Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

We reserve the right to make the revised or changed notice effective for protected health information we have about you as well as any protected health information we receive in the future. If we materially change our privacy policies and procedures, we will revise this notice so that you will have a current summary of our practices. The Plan Administrator and/or third-party vendor of the Plan may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Plan (and benefit component plans/programs, as applicable).

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider.

Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities and population based activities relating to improving the health of plan participants and reducing healthcare costs. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but

only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

For Explanation of Benefits.
When we process a claim for benefits under the health plans, we will mail an explanation of benefits ("EOB") to the primary participant at the address we have on file. These EOBs contain protected health information and may be for the claims of the primary participant or dependents of the primary participant covered under the Plans.

To Plan Sponsors.
For the purpose of administering the Plan, we may disclose your protected health information to certain employees of TLC (or any related entity/entities). For example, protected health information may be disclosed to Human Resources and Legal staff responsible for reviewing claims and appeals under the Plans' claims procedures. Protected health information may be disclosed to Human Resources, accounting and finance staff for purposes of gathering eligibility and claims data necessary for external auditors to perform audits. Protected health information also may be disclosed to Legal attorneys and paralegals in connection with appeals of denied claims under the Plans or in connection with a use or discloser of protected health information permitted or required by the HIPAA Privacy Rule. Protected health information also may be disclosed to finance, accounting and internal audit staff for financial purposes such as reconciling bank accounts and performing financial audits. Your protected health information cannot be used for employment purposes without your specific authorization.

Given the uncertainty of the current times, laws and/or regulations may change throughout the year. In such situations, the Plan will be interpreted based on guidance released and the Plan Administrator will interpret provisions as necessary, on a uniform and nondiscriminatory basis, for the operations of the Plan.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness. For example, workers' compensation programs generally provide benefits for work-related injuries or illness. Such determinations will be made in the sole discretion of the Plan Administrator in accordance with applicable rules.

Public Health Risks. We may disclose your protected health information for public health actions. These actions generally include the following: (1) to prevent or control disease, injury, or disability; (2) to report births and deaths; (3) to report child abuse or neglect; to report reactions to medications or problems with products; (4) to notify people of recalls of products they may be using; (5) to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or (6) to notify the appropriate authority governmental if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Victims of Abuse, Neglect or Domestic Violence.
To clarify, we may disclose your protected health information to a government authority that is authorized to receive reports of abuse, neglect, or domestic violence.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official, if necessary (1) for

the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Uses and Disclosures Requiring an Opportunity to Agree or Object. In certain circumstances, we may use or disclose protected health information as long as you have had the opportunity to agree to prohibit or restrict the disclosure of protected health information. If you are not present, or the opportunity to agree or object cannot practicably be provided, we may exercise our professional judgment and determine that it is in your best interest to disclose your protected health information.

Notice. Given the uncertainty of the current times, laws and/or regulations may change throughout the year. In such situations, the Plan will be interpreted based on guidance released and the Plan Administrator will interpret provisions as necessary, on a uniform and nondiscriminatory basis, for the operations of the Plan

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach. We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney).

Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or
(2) treating such person as your personal representative could endanger you; and
(3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above, , including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

If you revoke your authorization, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization, unless we are permitted or required to do so by law. You understand that we are unable to rescind any disclosures we have already made pursuant to your authorization. To revoke an authorization, contact T.L. Cannon Corporation, Human Resources, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221 attn: Benefits Administrator/Analyst

You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights. You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your healthcare benefits. To inspect and copy your protected health information, you must submit your request in writing to T.L. Cannon Corporation, Attention Human Resources, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

Sometimes Business Associates hold the protected health information on behalf of the Plans. If we do not maintain the protected health information that you are requesting and we know where the protected health information is maintained, we will tell you where to direct your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed, and you will be provided with details on how to do so.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in a Designated Record Set by or for the Plan.

To request an amendment to your protected health information, you must submit your request in writing to T.L. Cannon Corporation, Attention Human Resources, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221. In addition, you must provide a reason that supports your request and will receive more specifics as applicable to your situation.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To accounting of disclosures, you must submit your request in writing to T.L. Cannon Corporation, Attention Human Resources, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request.

Your request must state a time period for the disclosures you want us to include. You have a right to one free accounting of disclosures in any 12-month period. However, we may charge you for the cost of providing any additional accounting of disclosures in that same 12-month period. We will notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

Right to Request Restrictions.
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. If we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided below under Contact Information. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Additional Privacy Protections. You have the right to request that we further restrict the way we use and disclose your protected health information for treatment, payment or healthcare operations. You may also request that we limit how we disclose protected health information about you to someone who is involved in your care or the payment for your care.

Note: We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted by law. If we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction.

To request restrictions, you must submit your request in writing to T.L. Cannon Corporation, Attention Human Resources, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221. Your request must include all of the

following information: (i) what protected health information you want to limit; (ii) whether you want to limit how we use the protected health information, how we share it with others, or both; and (iii) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request more confidential communications, you must make your request in writing to T.L. Cannon Corporation, Attention Human Resources, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to be Notified of a Breach of Your Protected Health Information. You will be notified if any of your protected health information has been breached in accordance with HIPAA's breach notification requirements.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

2023 Notation:
For 2023, the OHCA is aware of the recently issued newsletter from Health and Human Services concerning the importance of cybersecurity awareness (and real-world examples provided in that document). As addressed, the OHCA will place cybersecurity awareness falls under the HIPAA Security Rule provisions which covers electronic protected health information (ePHI). As stated above, PHI is information about a participant's past, present, or future physical or mental health condition and information about payment for medical care or treatment which could be used to identify the participant. When the information is transmitted or maintained in electronic form, it is known as ePHI and falls under HIPAA's Security Rule with additional deference and protections under HIPAA's Privacy Rule which regulates the physical security and confidentiality of PHI in all formats.

T**o obtain a paper copy of this notice, please contact**:
T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, write to the Privacy Officer as provided below under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records. To file a complaint, contact T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118. All complaints must be submitted in writing.

HIPAA Privacy Officer / HIPAA Security Officer / HIPAA CONTACT PERSON

HIPAA PRIVACY OFFICER:
Susan Sabio
180 Lawrence Bell Dr., Suite 100
Williamsville, New York 14221
716.634.7700

HIPAA SECURITY OFFICER:
John Perry
180 Lawrence Bell Dr., Suite 100
Williamsville, New York 14221
716.634.7700

HIPAA PRIVACY &
HIPAA SECURITY CONTACT PERSON:
Benefits Administrator/Analyst
180 Lawrence Bell Dr., Suite 100
Williamsville, New York 14221
716.634.7700

No Retaliation

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us. We will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against you (for any other individual) for the exercise of any right established under the HIPAA Privacy Rule, including filing a complaint with us or with the Secretary of Health and Human Services; testifying, assisting or participating in an investigation, compliance review, proceeding or hearing under the HIPAA Privacy Rule or opposing any act or practice made unlawful by the HIPAA Privacy Rule, provided that you (or the individual) have a good faith belief that the practice opposed is unlawful and the manner of the opposition is reasonable and does not involve a disclosure of protected health information in violation of the HIPAA Privacy Rule. We will not require you to waive your privacy rights under the HIPAA Privacy Rule as a condition of treatment, payment, enrollment in the plans or eligibility for benefits. ***You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.***

Changes to This Notice

In December 2020, health and Human Services (HHS) issued a Notice of Proposed Rulemaking that outlined several changes to the HIPAA Privacy Rule based on responses they received back in 2019. In 2021, HHS again requested comments on the proposed HIPAA changes; however, the final rule has not been published yet. If the final rule is published, the OHCA will implement changes as applicable to the OCHA as determined in the sole discretion of the Plan Administrator.

We reserve the right to change our Privacy Policies and Procedures and this Notice at any time. We reserve the right to make the revised or changed Notice effective for protected health information we already have about you as well as any protected health information we receive in the future. If we materially change our Privacy Policies and Procedures, we will revise this Notice so that you will have a current summary of our practices.

General Statement Concerning Compliance with HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the employer agrees to the following:

(1) The employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that

the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth for compliance With HIPAA Privacy Standards, applicable to authorized employees, and the employer certification.

GDPR

The European Union's (EU) General Data Protection Regulation (GDPR) provides six lawful bases for processing personal data of natural persons (data subjects) located in the EU:

A. The data subject has given specific consent.
B. It is necessary for purposes of the legitimate interests pursued by the controller or by a third party and is not overridden by the interests or fundamental rights and freedoms of the data subject (particularly where the data subject is 16 years of age or younger).
C. It is necessary for the performance of a contract to which the data subject is party or in order to take steps at the request of the data subject prior to entering into a contract.
D. It is necessary for compliance with a legal obligation.
E. It is necessary in order to protect the vital interest of the data subject or another natural person.
F. It is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller.

In addition to the use of consent as a lawful basis for data processing, consent must often be obtained if "special category" data is being collected from a data subject. When collecting data under one of the other five lawful bases, a data subject must be provided with an explicit privacy notice.

Processing "Special Category" Data

Under the GDPR, personal data is considered to be special category data where it reveals racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership. It also includes the processing of genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health, or data concerning a data subject's sex life or sexual orientation.

As is relevant, special category data cannot be processed unless data subject consent is obtained, or: (1) it is necessary to carry out rights and obligations of the data subject or processor in employment; (2) the data subject is physically or legally incapable of consenting and the processing is necessary to protect the vital interests of the data subject or another natural person; (3) the data has already been manifestly made public by the data subject; (4) it is necessary for the establishment, exercise, or defense of legal claims; (5) it is necessary for specified public health reasons; (6) it is necessary for health-care related reasons, including assessing the work capacity of an employee, and those individuals involved in processing the data have duties of confidentiality; or (7) it is necessary for archiving purposes in the public interest, scientific or historical research purposes, or statistic purposes – and appropriate safeguards are in place.

When a Privacy Notice is Required Under the GDPR

An explicit privacy notice is generally required for any lawful processing of personal data under the GDPR where the lawful basis for that processing is not the consent of the data subject. If a privacy notice is required, it must be provided: (1) when personal data is collected from residents of the European Union (EU); (2) when initial contact is made with an EU resident whose personal data was obtained indirectly, or within one month of obtaining the data, whichever comes first; or (3) prior to using data for a purpose other than the one originally stated when that data was collected.

An explicit privacy notice is not required when: (1) it would be impossible, or involve a disproportionate effort; or (2) the data subject already has the required notification information.

To the extent applicable (and there is no admission of same), TLC (and its related entities) will adhere to the European Union's GDPR requirements, but only if and to the extent such requirements are actually applicable to such entities. If you have any questions/concerns about TLC and GDPR, please contact Human Resources, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

Additional Election Changes Permitted Beginning January 1, 2016 (Applies Only to Premium Payment Benefits for Medical Plan Coverage).

The Plan's provisions regarding election changes during the Plan Year have been amended to allow the following additional election changes beginning January 1, 2016:

• If you were reasonably expected to average thirty (30) hours of service or more per week and experience an employment status change such that you are reasonably expected to average less than thirty (30) hours of service per week, you may prospectively revoke your election for Medical Plan coverage, provided that you (i) request the election change within the Plan's election change period and (ii) certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform that is effective no later than the first day of the second month following the month that includes the date the Medical Plan coverage is revoked.

• If you are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during a special or annual open enrollment period, you may prospectively revoke your election for Medical Plan coverage, provided that you (i) request the election change within the Plan's election change period and (ii) certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective beginning no later than the day immediately following the last day of the Medical Plan coverage. These additional election changes will become effective no earlier than the first day of the next calendar month following the date that the election change request is filed (as determined by the Plan Administrator, election changes may become effective later to the extent that the other coverage commences later), and will remain in effect for the rest of the Plan Year unless a subsequent event recognized under IRS regulations or other guidance allows for a further election change. Election changes under this provision are subject to the terms and conditions of the Medical Plan and will not be permitted unless a corresponding change is allowed under that plan (i.e., to drop Medical Plan coverage for you or related individuals during the Plan Year).

If you have any questions regarding the information in this notice, or if you would like a copy of your Summary Plan Descriptions (which contains important information about plan benefits, eligibility, exclusions, and limitations), you should contact the plan administrator at T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

EAP PROGRAM

TLC offers various voluntary employee assistance program benefits under the TLC employee assistance program, a benefit plan contained under the T.L. Cannon Group Insurance Plan which is a health and welfare benefit plan(the "EAP Program") and the EAP program benefits are available to all employees. These benefits are referred to in this document as ("Voluntary EAP Benefits"). The Voluntary EAP Benefits program is administered according to federal rules permitting employer-sponsored of this nature, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, (all only to the extent and if applicable), among others. If you choose to participate in the program, you may be asked questions about your health-related activities and behaviors and whether you have or had certain medical conditions. You are not required in any situation to complete a health risk assessment ("HRA") or to participate in the blood test or other medical examinations. Again, this is a purely voluntary program.

If you do choose to participate in the EAP program you may receive an incentive as meaning the benefits conferred by the program. To receive those benefits, you may be required to complete certain activities and/or meet requirements. You are not required to complete those activities and/or meet those requirements. However, employees who choose to participate in the wellness program will receive an incentive as the benefits provided by the EAP program. So, although you are not required to complete the activities and/or meet the requirements, only employees who do so will receive the benefits provided by the EAP program.

The information you provide by doing EAP program activities and/or meeting EAP program requirements will be used to provide you with information to help you understand your current health, and may also be used to offer you services through the EAP program. You also are encouraged to share your results or concerns with your own doctor.

Additional incentives may, at some point, be available under the program for employees who participate in certain health-related activities or achieve certain health outcomes. If this happens and if you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118. TLC will work with you, and, if you wish, with your doctor (in accordance with all applicable law(s)), to find an employee assistance program with the same reward that is right for you in light of your health status.

In order to provide the Voluntary EAP Benefits, the Plan must obtain certain types of EAP Medical Information.

EAP Medical Information That May Be Obtained By the Plan.

The EAP Medical Information obtained will depend on the elections made by a participant (or beneficiary, only as applicable) and whether he/she decided to voluntary participate and provide such EAP Medical Information.

How the EAP Medical Information Will Be Used / Protections From Disclosure

Any EAP Medical Information will be used solely to administer the Voluntary EAP Benefits under the Plan. The applicable vendors that agreed to be bound by Business Associate Agreements (BAAs) in accordance with the health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. Further, your employer will only receive EAP Medical Information in aggregate form that does not disclose, and is not reasonably likely to disclose, the identity of specific employees.

Restrictions On the Disclosure of EAP Medical Information.

We are required by law to maintain the privacy and security of your personally identifiable health information and have included the EAP in our HIPAA OHCA. Although the EAP program and TLC may use aggregate information it collects to design a program based on identified health risks in the workplace, the EAP Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the EAP program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the EAP program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the EAP program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the EAP program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the EAP program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are identified in the OHCA HIPAA Privacy Notice included with these notices. Any disclosure will only be made in order to provide you with services under the EAP as described in the HIPAA Privacy Notice.

In addition, all medical information obtained through the EAP program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the EAP Program will be used in making any employment decision. Also see the HIPAA Notice of Privacy Practices. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the EAP Program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Please contact T.L. Cannon Corporation, Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.

PLAN AMENDMENT & MODIFICATION/RE-DISCLOSURE TO SPD EFFECTIVE:	**JANUARY 1, 2023**
NOTICE FOR SECTION :	**Appendix A: Eligibility Schedule**
INSTRUCTIONS:	**The Appendix A Eligibility Schedule consisting of: (A) the General Eligibility Rules and (B) the Full-Time Employee Policy which is an addendum to the Eligibility Rules dated January 1, 2017 remains in full force and effect. If you would like an additional copy of the Eligibility Schedule, eligibility rules, please contact the Plan Administrator: Attention Benefits Administrator/Analyst, 180 Lawrence Bell Dr., Suite 100, Williamsville, New York 14221, 716.634.7700 x8118.**

Given the uncertainty of the current times, laws and/or regulations may change throughout the year. In such situations, the Plan will be interpreted based on guidance released and the Plan Administrator will interpret provisions as necessary, on a uniform and nondiscriminatory basis, for the operations of the Plan.
