Empire State Merit Apprenticeship Alliance, Inc.
EBT Employee Manual

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Introduction

Your employer has adopted an ERISA Health and Welfare benefit plan to collect the fringe supplement dollars that you earn, and use those fringe supplement dollars to purchase and/or provide qualified benefits for you. Health and Welfare benefit plans have been widely used by construction companies, since their inception in 1974, to insure the proper delivery of benefits to their field employees. These plans are regulated by the USDOL under the Employee Retirement Income Security Act (ERISA), and this Plan is one of the most advanced available in the marketplace. As a plan participant, you will have your own separate account into which the fringe supplements you earn will be deposited. There is no commingling of your funds with any other funds, and there is no vesting or participation requirement in order to receive benefits. All deposits made by your employer on your behalf are irrevocable.

By adopting this Plan, your employer will save certain taxes and insurance costs known as "payroll burden", which will allow them to bid more competitively. In addition, this Plan provides every employee with "third-party" accounting of his or her fringe supplement dollars.

The Trustee for this Plan is M&T Bank Corporation. This means that your account balance is held at M&T Bank which is subject to federal banking regulations.

GMR Associates, Inc. (GMR) is the third-party administrator of this Plan and specializes in providing benefits and services to the construction trades. As third-party administrator, GMR is responsible for the accounting of your employer's funds and payment of qualified benefits on your behalf. These benefits may include: insured benefits, such as medical and dental insurance, and cash benefits such as vacation, holiday, sick pay, training and supplemental unemployment. If applicable, GMR will also be responsible for allocating and depositing funds into your qualified retirement plan. The administration of this Plan is subject to a certified audit each year, and GMR is covered by an ERISA fiduciary bond,

employee dishonesty insurance and errors and omission insurance. As third-party administrator, GMR is your point of contact for questions concerning your account.

This Plan is an ERISA Health and Welfare Trust that is regularly audited and routinely reviewed for compliance by ERISA, Labor and Tax counsel.

Fringe Supplements

Federal and state prevailing wage laws have been enacted to mandate certain levels of wages and benefits paid on public projects. These laws set the base rate of pay, or "prevailing wage", that the contractor must pay an employee working on these projects. These laws also stipulate an additional dollar amount per hour, known as the “fringe supplement,” that is intended to be used to provide fringe benefits to the employees working on these projects.

Under the law, your employer may either purchase fringe benefits with the fringe supplement, or pay the fringe supplement directly to employees in addition to the prevailing wage base rate. Although this sounds good, it is not necessarily beneficial to the employees or to your employer.

If your company pays the fringe supplement to the employee in their paycheck, the employee must pay taxes on them like regular wages – and he or she does not get the advantages of health insurance, a retirement plan, or other fringe benefits. Your employer must also pay taxes and payroll-based insurance costs on these monies. This is known as the "payroll burden," which does not have to be paid if the monies are used to purchase fringe benefits. Many times, these additional payroll burden cost make your employers bids non-competitive.

In addition, the New York State Department of Labor (NYSDOL) Annualization Regulations impose further costs on the contractor. The result of these regulations is to equalize fringe benefit contributions between public and private work hours for each employee. Many employers comply with this regulation by adopting a prevailing wage model of pay (base rate plus a fringe supplement) for all private hours worked. Using the private hour fringe supplements and the prevailing wage fringe supplements together to purchase benefits maximizes your employer's competitiveness in the bidding process while complying with the NYSDOL regulations.

Your employer has decided to use the prevailing wage and private hour fringe supplements to purchase "bona fide" fringe benefits on your behalf. This booklet will describe the ERISA Health and Welfare Trust that has been set up to provide you a carefully designed "bona fide" benefits program. This ERISA Health and Welfare Trust will also provide an accounting of the fringe supplements earned by you. **All fringe supplements are employer dollars used to purchase benefits on your behalf.**

Empire State Merit Apprenticeship Alliance, Inc.
Employee Benefit Master Welfare Plan
Effective: 9/20/2012; Revised: 1/3/2019

Each time fringe supplement dollars are deposited into your Trust account they are placed into the first "bucket" of your employer-designated cascade. The first bucket captures the funds it needs to pay for benefits before allowing unused money to flow to the second bucket. The second bucket collects the funds it needs to pay for benefits, and then unused money flows to the third bucket. This process repeats itself down the entire cascade.

Benefit | **Cascade**

401(k) Profit Sharing Plan:
Collects 5% of period deposit amount.

Payments: Each week, supplements collected in this bucket will be transferred directly to your retirement plan administered by the pension plan provider selected by the Merit Alliance. Deposits sent to the retirement plan from the Trust will be invested according to the percentages designated by the apprentice on their retirement plan enrollment form.

Insurance Premiums:
Collects the current month's premium plus five (5) months of reserves (default). Individual collection amounts established by the Merit Alliance.

Premium amounts, coverage levels and insurance providers depend on plan enrollment and insured level. Premiums subject to change by the insurer.

Payments: Each month, supplements will be used to pay the premium(s) due. Any premiums, or portion of a premium due that cannot be paid from the supplements available in this bucket are the responsibility of the apprentice. If this bucket does not have enough funds to pay for the premium currently due, funds can be transferred from other buckets, if available, at the Merit Alliance's discretion.

Training:
Collects a maximum of $3.00 for each hour worked, maximum of $4,500 per 12 month period (default). Individual collection amounts established by the Merit Alliance.

Payments: Supplements collected and available in this bucket are to provide training benefits to the apprentice as determined by the Merit Alliance.

Holiday:
Collects a maximum of $0.65 for each hour worked, maximum of $1,000, to provide Holiday benefits as determined by the Merit Alliance (default). Collection amount subject to change. Individual benefit amounts may be established by the Merit Alliance.

Payment: Supplements collected and available in this bucket are for payments to the apprentices for
Holiday benefits based on Merit Alliance paid holiday policy.

Vacation/Sick:
Collects a maximum of $1.00 for each hour worked, maximum of $1,500, to provide Vacation/Sick benefits as determined by Merit Alliance (default). Collection amount subject to change per local, state and/or federal guidelines. Individual benefit amounts may be established by the Merit Alliance.

Payment: Supplements collected and available in this bucket are for payments to the apprentices for Vacation/Sick benefits based on Merit Alliance paid vacation/sick policy.

CTT Training:

Collects a maximum of $1.00 of supplements for each hour worked (default). Individual benefit amounts may be established by the Merit Alliance.

Payments: Supplements collected and available in this bucket are to provide training benefits to the apprentice as determined by the Merit Alliance.

Supplemental Unemployment:

Collects the balance of fringe supplements. If no funds have accrued in this bucket, then no benefit is available.

Your Trust account will pay a Supplemental Unemployment benefit calculated by formula **only** when you are involuntarily separated from employment due to seasonal layoff/ short week/reduced hours/partial layoff status. The weekly max of this benefit is calculated by the Merit Alliance and is subject to change.

How to File a Supplemental Unemployment Claim:

1. Go to the "Apprentice Documents" section of our website http://meritalliance.org/our-apprentices/apprentice-documents/ Password: newhire
2. Go to the final document in the list ("Benefit Claim Form - SUI, Vacation for Current Apprentices") for an online form. You will not need to print anything. Enter the requested information and click on "submit form" at the bottom. The form gets sent directly to HR Coordinator Carolyn Steinhauer by email. She will confirm receipt. Note: this form does not work well on a phone or when using Chrome. Use another browser.
3. Note, the Supplemental Unemployment Benefit will be paid based on your Alliance defined private hourly wage x 8 hours per day. Funds will only be distributed if funds are available in your SUI bucket. If no funds are available, no benefit can be provided.
4. You must submit a request for each week unemployed. The deadline is Monday 8 am for claims for the previous week.
5. This form can also be used to claim vacation. Funds will only be distributed if there are funds in your vacation/holiday bucket. If no funds are available, no benefit can be provided.

SIGNED SUPPLEMENTAL VERIFICATION FORM MUST BE ON FILE TO BE ELIGIBLE FOR PAYMENTS.
PAYMENTS FULLY TAXABLE (excluding employer/ apprentice FICA) AS INCOME AND REPORTED ON IRS W-2.

NOTE: Any funds remaining in your Trust account following separation from the apprenticeship program (graduation, resignation or termination) will be transferred by GMR to your 401(k), up to the maximum amount allowed by regulation. Note, there is a standard 90-day waiting period before remaining Trust funds will be released to your 401(k) account.

Employee Communication

GMR Contact Information:

Phone Number	585-429-1330 or 1-800-724-4817
Customer Service Ext	130
Trust Accounting Ext	201
Automated Benefit Requests Ext (Supp Unemp/Vacation)	200
Fax Number	585-426-6981
General Website Address:	www.gmr-usa.com
Forms Website Address:	www.gmr-usa.com/forms

- Direct Deposit Forms
- Supp Unemp Verification Form
- NYS/Federal Withholding Forms
- Electronic Statement/Check Stub Waivers
- Etc.

Online Access/Mobile App:

If offered by your Employer, online access to your Trust account is also available. You will be able to view up-to-date bucket balances, general transactions, bucket enrollments and benefit statements, submit benefit requests if applicable, and view any pending requests submitted. A mobile app is also available for iPhone/iPad & Android devices. Search the corresponding App Store on your device for "GMR EBT". This service is only available if your Employer has elected to offer online access. Availability is determined by your Employer, not GMR.

Below are the steps required in order to setup a new online account:
1.) Go to www.gmr-usa.com
2.) Click the button "Employee Trust Account"
3.) On the login screen click the "New User?" button
4.) Fill in your SSN/Employee Number and 5 digit postal zip code. Click "Next"
5.) Check the confirmation box if your information is correct
6.) Enter a valid E-Mail address and password, and click "Next"
7.) You should receive a message that your account has been created. Click the link to login using the E-Mail address and password you created in step 6.

Please note, GMR reserves the right to change/modify/remove any and all online features at any time and makes no uptime guarantee for this service.

Trust Statements:

GMR prepares comprehensive Employee Statements on a monthly basis. These statements will be available electronically on our website under the "Tools" section. They will also be available in Employee Online Accounts/Mobile App if applicable. You may choose to waive out of electronic delivery by completing a waiver form which is available on our website. Monthly Trust statements will show how much fringe supplements were received for that period and how that money was allocated in the Trust. It shows the deposits, payments, transfers, administration and transaction fees, and any other activity in the Trust for that period. Keep in mind that your fringe supplements are sent from your Employer to GMR;

GMR can only report for funds GMR has received. If you have a pension bucket in EBT, please be aware that your pension account is a separate entity. Since GMR transfers these funds directly to your pension account you will need to contact your Pension Administrator for actual pension balances.

Termination of Employment:

If your employment is terminated, your Plan coverage will be continued until the last day of the calendar month in which your termination occurs, provided you reimburse the Employer for any cost of monthly coverage that you are required to pay as an active employee. Any funds remaining in your Trust account(s) beyond this point will be transferred to your retirement plan (to the fullest extent allowable by regulations.) After completion of this transfer, any excess funds in you Trust account will be paid directly to you (taxable as wages) after a termination processing fee has been deducted. There is a standard 90-day waiting period before remaining funds will be released in your account.

Lay-off Coverage:

Your coverage with respect to benefits under the Plan will not terminate during a period of seasonal layoff, if, in the case of an Insurance Benefit, there is sufficient money allocated to your Insurance Accounts to pay premiums with respect to the benefit.

Leave of Absence Coverage:

If you take a leave of absence (including a disability or workers' compensation leave) while participating in this Plan, your coverage may continue while you are on leave as required by law and as otherwise permitted under your Employer's leave policy relevant to the type of leave you are taking.

Benefit Taxation

All cash benefits from the Trust are fully taxable as ordinary income and reported on IRS Form W-2. Cash benefits paid from the Trust are not wages. IRS Form W-2 will be processed at the completion of the calendar year and mailed for distribution as soon as they are available as required by law.

We would like to remind all participants of the GMR Trust who receive any "cash benefit" checks subject to State or Federal Income Tax (such as Vacation/Sick/Holiday and Supplemental Unemployment) to please take time to make sure that your withholdings are sufficient to cover your personal income tax obligations. The payment of your personal income tax (either with your return or through withholding) always falls to you, the employee. Your Employer and GMR Associates are not responsible for any shortages when it comes time to pay your tax obligation and/or receive your tax refund. We stress the importance of periodically checking your check stubs to ensure that your withholdings are sufficient to cover your personal income tax obligations.

If you feel you could be at risk of too little tax being withheld, please make sure you contact your tax advisor for advice. You might want to consider having extra taxes withheld from your checks. You can make this request by filling out a W-4 Form and sending it to either your Employer, or to the GMR Trust Accounting Department.

Excess Contributions Trust Year-End Calculation

Each year on June 30th, the Trust will disburse all excess contributions made to your Non-Insurance Benefit account(s) that have not been used to provide you benefits. These excess contributions may be used to fully fund your insurance reserves, and/or transferred to your retirement plan (to the extent permitted). Any balance remaining will be paid directly to you. The excess contributions distributed directly to you from the Trust are taxable as wages. Taxes will be withheld from the distribution and you will receive an IRS Form W-2.

- The current year-end calculation is to fill the Insurance sub-account, maximize the 401(k) Profit Sharing Plan (as determined by the Employer) and then distribute the balance of the Non-Insurance Accounts to the participant as cash
- The year-end calculation parameters are determined by the Employer each year and subject to change.
- Distribution payments are fully taxable to the employee as ordinary income and reported to the IRS on a Form W-2 issued by the Trust.
- Trust year-end is June 30th, with distributions made on, or about, July 31st.
- If maximizing the insurance reserves, and maximizing the pension is at 100% of YTD gross wages depletes the balances in the Non-Insurance Account(s), there will be no cash year-end distribution.

General Questions

What is the EBT?
The "Employee Benefit Trust" (EBT) is an ERISA welfare benefits plan adopted by your Employer, designed to collect fringe supplement dollars you have earned and use those fringe supplements to pay for qualified benefits for you.

How does the EBT work?
Your Employer sends the fringe supplement dollars earned by you to the EBT. These funds will be used to provide your benefits as selected by your Employer. Each employee has an individual (allocated) account. Funds can only be taken out of the EBT for payment of qualified benefits and expenses. Funds allocated to your account can only be used toward payment of your benefits and costs associated with providing those benefits. If your Employer has adopted the Trust, you must be enrolled in it. Fringe supplement dollars are deemed by Federal and State law to be Employer dollars. They must however, be used to pay, or provide benefits for, the employee that has earned them. Fringe supplements are not employee elective deferrals. Consequently, your Employer can send fringe supplements to the Trust without your written approval. General Trust enrollment forms are used however, to provide the EBT with information to establish your benefit account(s). Your Employer selects the order and amount of each of the buckets based on the benefits they wish to provide. This cascade must be the same for all participants. GMR, along with your Employer, will monitor the effectiveness of the benefit cascade for all employees in the EBT to ensure that the employees' fringe supplement dollars are allocated toward the highest priority benefits and make changes to the "cascade", if necessary.

What are "buckets"?
This is the term we have chosen to describe the accumulation of funds in each of your EBT sub-accounts. You may have buckets for insured benefits, such as medical and dental

insurance, or non-insured benefits, such as vacation, holiday, sick, training, retirement plan and supplemental unemployment.

What do you charge me for participating in the Trust?
GMR charges an administrative fee on all non-pension Trust deposits of prevailing wage fringe supplement dollars. Also, there is an annual $11 professional fee charged. In addition, small charges may be assessed for payment of benefits from the Trust. These fees are used by GMR to maintain and update plan documents, coordinate the use of the Welfare Benefit Plan between the Employer, Trustee and GMR, receive and maintain records of Employer contributions, establish individual participant accounts, allocate contributions, pay benefits as directed by the Employer, report payroll withholding on any cash disbursement, produce periodic reports and maintain records of all accounts.

SUMMARY PLAN DESCRIPTION
OF THE WELFARE BENEFITS PLAN OF
Empire State Merit Apprenticeship Alliance, Inc.

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This Summary Plan Description ("Summary Plan Description") replaces all other Summary Plan Descriptions and other communications regarding the above-named Plan and no reliance should be placed on any statements previously made in any of those documents. This Summary Plan Description is not intended to be an employment contract between any participating Employer/Plan Sponsor and its employees.

SUMMARY PLAN DESCRIPTION
OF THE WELFARE BENEFITS PLAN
OF Empire State Merit Apprenticeship Alliance, Inc.

INTRODUCTION

Empire State Merit Apprenticeship Alliance, Inc. (the "Employer/Plan Sponsor") is pleased to present you with this Summary Plan Description ("SPD") of the Welfare Benefits Plan of Empire State Merit Apprenticeship Alliance, Inc. (the "Plan") which became effective 10/1/2007 to provide welfare benefits to its employees and the employees of its affiliated companies that participate in the Plan. The actual welfare benefits and coverage options available under the Plan are described in the appendices of this SPD.

The names of the companies in addition to the Employer/Plan Sponsor who have adopted the Plan for their employees (called "Participating Affiliates") are listed in *Appendix A-- Additional Information about the Plan.*

References in this SPD to "the Employer/Plan Sponsor" refer to Empire State Merit Apprenticeship Alliance, Inc. even though you may actually be employed by a Participating Affiliate. References in this SPD to "you" refer to the Employee who is covered by the Plan.

This SPD is a summary of the more important provisions of the Plan. To make this summary clear and concise, some Plan provisions are only described in abbreviated form, and others are not mentioned at all. The official Plan documents include an Adoption Agreement, a Basic Plan Document, a Trust Agreement and Insurance Contracts, as well as this SPD. All of these documents taken together contain all of the provisions of the Plan and are used to determine how the Plan operates, what benefits are paid and who is eligible to receive them. Therefore, you must read all of these documents if you need a complete statement of the Plan's provisions.

You may review the other Plan documents in addition to this SPD at the office of the Employer/Plan Sponsor during normal business hours. You may obtain a copy of the other Plan documents from the Employer/Plan Sponsor upon payment of a copying fee. If you have any questions about the Plan or your benefits under the Plan, please contact the Employer/Plan Sponsor at the address provided in *Appendix A -- Additional Information about the Plan.*

Capitalized terms used in this SPD are defined in the section entitled **GLOSSARY**.

HOW THE PLAN OPERATES

The Employer/Plan Sponsor established the Plan by adopting the GMR Associates Employee Benefit Master Welfare Plan (the "Master Plan"). Under the terms of the Master Plan, the Employer/Plan Sponsor makes periodic cash contributions to the GMR Associates Employee Benefit Master Welfare Trust (the "Trust"). These cash contributions may include Employer/Plan Sponsor monies ("Employer/Plan Sponsor Contributions") or monies deducted from your pay ("Employee Contributions") or both. See the section entitled ***CONTRIBUTIONS UNDER THE PLAN*** later in this SPD.

Money contributed to the Trust on your behalf is allocated to one or more accounts established in your name and for your exclusive benefit by GMR Associates, Inc. (the "Third Party Administrator"). This money may be used to pay premiums required to purchase Insurance Benefits for you and your Dependents or used to pay Non-Insurance Benefits directly to you. While this money is held in the Trust, it may be invested by the Trustee.

The Employer/Plan Sponsor is responsible for making contributions to the Trust at the times and in the amounts necessary to pay premiums required to be paid in order to continue your coverage under the Insurance Benefits. The Third Party Administrator is responsible for seeing that amounts allocated to your Insurance Account(s) are used to pay these premiums in a timely manner. ***However, the Third Party Administrator has no obligation to collect additional contributions from the Employer/Plan Sponsor even if the amount allocated to your Insurance Account is insufficient to pay premiums.***

If you become entitled to payment under a Medical Benefit or other Insurance Benefit, you must submit a claim to the Insurance Company that underwrites the Insurance Benefit in accordance with the claim procedures described in the applicable Insurance Contract.

Your claims for Non-Insurance Benefits must be submitted to the Employer/Plan Sponsor in accordance with the claim procedures established by the Employer/Plan Sponsor. The amount of Non-Insurance Benefits payable to you cannot exceed the amount of money allocated to your Non-Insurance Account under the Trust at any given time. The Sponsor is responsible for seeing that amounts allocated to your Non-Insurance Account are used to pay Non-Insurance Benefits. ***However, the Third Party Administrator has no obligation to collect additional contributions from the Employer/Plan Sponsor even if the amount allocated to your Non-Insurance Account is insufficient to pay such benefits.***

WELFARE BENEFITS THAT ARE PROVIDED UNDER THE PLAN

The Employer/Plan Sponsor decides what welfare benefits will be provided under the Plan. These benefits may be either Insurance Benefits or Non-Insurance Benefits or both kinds of Benefits. ***The Benefits that have been selected by the Employer/Plan Sponsor, which are provided under the Plan, are listed in Appendices B, C and D attached to this SPD. The Employer/Plan***

Sponsor may not have selected all of the Benefits referred to in this SPD.

Insurance Benefits

Insurance Benefits that may be provided under the Plan-- if selected by the Employer/Plan Sponsor— include any one or more of the following benefits:

(1) Medical Benefits,
(2) Dental Benefits,
(3) Vision Benefits,
(4) Employee Life Insurance,
(5) Accidental Death & Disability Insurance,
(6) Long Term Disability Insurance,
(7) Short Term Disability Insurance.

These Benefits are called "Insurance Benefits" because they are provided by one or more insurance companies ("Insurance Companies") in accordance with the terms of insurance contracts entered between the Employer/Plan Sponsor and the Insurance Company.

Non-Insurance Benefits

Non-Insurance Benefits that may be provided under the Plan-- if selected by the Employer/Plan Sponsor-- include any one or more of the following benefits:

1. Vacation/Holiday/Sick Pay Benefits,
2. Job Training Benefits,
3. Supplemental Unemployment Benefits,
4. Supplemental Workers Compensation Benefits,
5. Health Savings Account Contributions,
6. Non-Elective Retirement Contributions.

These Benefits are called "Non-Insurance Benefits" because they are not provided by Insurance Companies. Instead, these benefits are paid directly from the Trust and are limited to the amount of money contributed to the Trust on your behalf and allocated to your "Non-Insurance Account."

All Non-Insurance Benefits that have been selected by the Employer/Plan Sponsor are fully paid for by the Employer/Plan Sponsor. They are described in *Appendix B - Description of Non-Insurance Benefits.* The Employer/Plan Sponsor has decided to provide these Benefits to all Eligible Employees and, therefore, if you are an Eligible Employee, your coverage under these Benefits is automatic.

Source of Benefit Payments

Insurance Benefits. Benefit payments made with respect to an Insurance Benefit are paid by the Insurance Company that underwrites the Benefit, in accordance with Insurance Contract issued by the Insurance Company. *Neither the Employer/Plan Sponsor, the Third Party Administrator, the Trustee nor any person other than the Insurance Company is liable to you for payments with respect to an Insurance Benefit*. The Trustee pays the premiums for your coverage under the Insurance Benefit with funds contributed to the trust by the Employer/Plan Sponsor and/or you and allocated to your Insurance Account under the Trust.

Non-Insurance Benefits. Benefit payments made with respect to Non-Insurance Benefits are paid exclusively with the funds allocated to your Non-Insurance Account, if any, under the Trust. Therefore, the amount of Non-Insurance Benefits that you can receive under the Plan cannot exceed the amount of contributions paid to the Trust by the Employer/Plan Sponsor on your behalf and allocated to your Non-Insurance Account under the Trust. The amount allocated to your Non-Insurance Account will be decreased by any Non-Insurance Benefits paid to you and may be increased by Trust investment income.

Insurance Booklets

The rules concerning who is eligible for coverage under an Insurance Benefit available under the Plan, when coverage under the Benefit begins and when coverage ends, which are set forth in this SPD, are subject to and superseded by any rules contained in the Insurance Contract applicable to the Benefits. In other words, if there is a conflict between the SPD and the Insurance Contract concerning a rule, the rule in the Insurance Contract will be applied under the Plan. When you receive coverage under an Insurance Benefit, you will usually be provided with a booklet (called an "Insurance Booklet") by the Insurance Company that underwrites the Benefit. The Insurance Booklet summarizes the terms set forth in the Insurance Contract. The Insurance Booklet is a part of this SPD and you should keep your copy of the booklet together with this SPD. Whenever this SPD refers you to an Insurance Contract, you may refer to the Insurance Booklet summarizing the Contract in lieu of reviewing the full Contract. As stated earlier, however, you do have the right to review the actual Insurance Contract at the Employer/Plan Sponsor's office during normal business hours.

WHO IS ELIGIBLE TO PARTICIPATE IN THE PLAN

Employees Who Are Eligible to Participate

You are eligible to participate in the Plan if:

(1) you are Actively Employed by the Employer/Plan Sponsor or a Participating Affiliate listed in *Appendix A -- Additional Information about the Plan*, and

(2) you are a non-union employee, and

(3) you have satisfied the following service requirement: N/A

You are not eligible to participate in the Plan if you are not receiving salary or wages as an employee directly from the Employer/Plan Sponsor, or an Affiliated Company listed in Appendix A. For example, if the Employer/Plan Sponsor is paying you as an independent contractor, or if some person or business organization other than the Employer/Plan Sponsor or a Participating Affiliate is paying your salary or wages, you are not eligible to participate in the Plan even though you may be considered an "employee" of the

Employer/Plan Sponsor or a Participating Affiliate under state or federal law.

Dependents Who Are Eligible to Participate

Generally, the following persons will be eligible to be covered as Dependents with respect to Medical, Dental and Vision Benefits:

(1) Your lawful spouse if you and he or she are not legally separated or divorced.

(2) Your unmarried child who has not reached the maximum age for Dependents applicable to the benefit option elected by you (i.e., a Dependent who has not "aged out").

(3) Your unmarried child who has aged out but who is incapable of self-sustaining employment due to mental illness, developmental disability, mental retardation or physical handicap which occurred prior to aging out and who is chiefly Dependent upon you for support and maintenance.

A "child" generally includes a child who is legally adopted, a stepchild, or a child who you propose to adopt who is either physically in your household or has been surrendered to you in court by the birth mother. Your children must be Dependent on you for support and live with you in a normal parent-child relationship. A child may also qualify for coverage whenever a "Qualified Medical Child Support Order" or "QMCSO" is submitted to the Plan. See the ***GLOSSARY*** at the end of this SPD.

The written materials provided to you by the Insurance Company that underwrites your Medical, Dental or Vision Benefit (as the case may be) describe which Dependents are eligible for coverage and when that coverage goes into effect. Please review these documents to determine whether your Dependents are eligible for such Benefits under the Plan.

WHEN COVERAGE UNDER THE PLAN BEGINS

Coverage under Employer/Plan Sponsor Pay Benefits

If you have satisfied the three requirements listed in the previous section for eligibility to participate in the Plan and you are entitled to receive one or more Employee Pay Benefits, your coverage under those Benefits will begin on your Entry Date.

If you satisfied the requirements for eligibility on the Effective Date of the Plan, your Entry Date will be the Effective Date of the Plan which is listed in Appendix A.

If you did not satisfy the requirements for eligibility on the Effective Date of the Plan (for example because you were not an employee on that date), your Entry Date will be the next Entry Date (listed in Appendix A) occurring after you have satisfied the eligibility requirements.

These general rules do not apply to an Insurance Benefit if the Insurance Contract that applies to the Benefit specifies a different date on which Benefit coverage will begin. Any such different date for the beginning of coverage will be specified in Appendix B- Description of Insurance Benefits --Employee Pay Benefits.

WHEN COVERAGE UNDER THE PLAN ENDS

Subject to special rules concerning coverage during periods of seasonal layoff, coverage during a leave of absence, coverage during military leave, and COBRA Continuation Coverage, coverage with respect to any Benefit under the Plan will terminate at the earliest of the following dates:

Termination of Coverage of an Employee

a. If your employment terminates for any reason, on the last day of the month in which your employment was terminated. (But see the section entitled *Coverage During Periods of Seasonal Layoff*, below.)

b. On the day that you are no longer a member of the class of employees eligible to participate in the Plan.

c. If you fail to pay any required contributions toward the cost of the Benefit on a timely basis, on the last day that was included in your timely payment for the benefit coverage.

d. On the effective date of your election to discontinue the Benefit.

e. If you submit a fraudulent claim for the Benefit, whether the claim is for yourself or a Dependent covered under the Plan, on the day that the claim is submitted for payment.

f. If you commit a crime in the course of obtaining payments under the Benefit or in submitting a claim for the Benefit, whether for yourself or a Dependent covered under the Plan, on the day that you commit the crime.

g. On the day that you fail or refuse to comply with the administrative procedures required by the Plan in obtaining or submitting claims for the Benefit for yourself or a Dependent covered by the Plan, unless the Plan provides a specific consequence (other than termination) for such failure or refusal.

h. On the day provided in a Plan amendment excluding the class of employees to which you belong from eligibility for the Benefit.

i. On the date that the Plan is terminated.

Termination of Coverage of a Spouse or Dependent

a. On the day there occurs any of the events resulting in termination of your coverage, as set forth above.

b. For your spouse, on the day before the file date of your divorce decree or legal separation.

c. For your Dependent, on the last day of the month when he or she no longer meets the criteria for an eligible Dependent.

d. If your spouse or Dependent submits a fraudulent claim for the Benefit, whether the claim is for himself or herself, the Employee or another Dependent covered under the Plan, on the day that the claim is submitted for payment.

e. If your spouse or Dependent commits a crime in the course of obtaining the Benefit or in submitting a claim for the Benefit, whether for himself or herself, the Employee, or another Dependent covered under the Plan, on the day that the crime is committed.

f. On the day that your spouse or Dependent fails or refuses to comply with the administrative procedures required by the Plan in obtaining or submitting claims for the Benefit for himself or herself, the Employee, or another Dependent covered by the Plan, unless the Plan provides a specific consequence (other than termination) for such failure or refusal.

The determination of whether an event described above has occurred will be made by the Insurance Company in the case of an Insurance Benefit, and by the Employer/Plan Sponsor in the case of a Non-Insurance Benefit. If you or your spouse or Dependent does not agree with the Insurance Company's determination, you or he or she may request an official review of the determination by following the procedures described in the applicable Insurance Contract. You may request an official review involving a claim for a Non-Insurance Benefit by following the steps set forth latter in this SPD, in the section entitled ***HOW TO FILE A CLAIM FOR BENEFITS***.

If your employment is terminated, your coverage will be continued through the last day of the calendar month in which your termination occurs ("termination month"), provided you reimburse the Employer/Plan Sponsor for the cost of the monthly coverage that you are required to pay as an active employee. Failure to reimburse this amount before the last day of the termination month will result in your coverage being discontinued on the last day of the month preceding your employment termination.

When your Medical, Dental or Vision Benefit is discontinued, you and your covered Dependents may continue such coverage by electing the coverage described in the *COBRA Continuation Coverage* section set forth below in this SPD.

These rules do not apply with respect to an Insurance Benefit if the Insurance Contract that governs the Benefit specifies a different date for the termination of coverage under the Benefit.

Coverage During Periods of Seasonal Layoff

Your coverage with respect to Benefits under the Plan (and coverage of your spouse or Dependent in the case of Medical, Dental or Vision Benefits) will not terminate during a period of seasonal layoff (regardless of whether you are considered to be an employee of the Employer/Plan Sponsor or a Participating Affiliate during that period for purposes outside the Plan) if: [1] in the case of an Insurance Benefit, there is a sufficient amount of money allocated to your Insurance Account to pay premiums with respect to the Benefit, and [2] in the case of a Non-Insurance Benefit, there is money allocated to your Non-Insurance Account available to pay the Benefit.

Coverage During a Period of Leave of Absence

[Only applies to plans of Employer/Plan Sponsors who generally employ 50 or more employees.]

The Family and Medical Leave Act of 1993 ("FMLA") entitles each "qualified employee" (as defined below) up to 12 weeks of unpaid leave during a 12-month period for the birth, adoption or foster care placement of a child; the serious health condition of a spouse, child or parent; or the employee's own serious illness. A qualified employee is generally an employee who has worked for an Employer/Plan Sponsor or an Affiliate for at least 52 non-consecutive weeks and has worked at least 1,250 hours in the 12-month period immediately preceding the leave.

CONTINUATION OF HEALTH COVERAGE

In compliance with the FMLA, the following rules apply to the continuation of Medical, Dental and Vision Benefits coverage ("Health Coverage") with respect to a leave of absence:

° Whenever you are on leave from work due to a disability or workers' compensation claim, up to the first 12 weeks of your leave will automatically be deemed a FMLA leave, if available. If your leave is FMLA leave, the Employer/Plan Sponsor will continue Health Coverage under the Plan while you are on leave, provided that you pay any Employee Contribution that you were required to pay as an active employee to the Employer/Plan Sponsor on a timely basis.

° If all or part of your disability or workers' compensation leave is not a FMLA leave (because you already had 12 weeks of FMLA leave in the preceding 12-month period), the Employer/Plan Sponsor will continue Health Coverage under the

Plan for as long as your paid sick leave lasts, provided that you remit Employee Contributions applicable to your coverage to the Employer/Plan Sponsor by the tenth of the month. After this period of coverage expires, you can continue Health Coverage (and your Dependents' coverage) while off work by reimbursing the Employer/Plan Sponsor for the full cost of coverage by the tenth of the month.

- In no event will your Health Coverage be continued under the Plan while you are on disability or workers' compensation leave for a period exceeding one year from the date that your leave began (subject to the rules described in the section entitled *COBRA Continuation Coverage*, set forth below).

- If you are authorized to take a leave under the FMLA, other than leave from work due to a disability or workers' compensation claim, you are entitled to continue your Health Coverage for the duration of your leave, provided that you pay any Employee Contribution applicable to your coverage to the Employer/Plan Sponsor by the tenth of the month.

- If you are authorized to take a leave of absence, other than FMLA leave or leave from work due to a disability or workers' compensation claim, or a military leave, you may continue Health Coverage by following the rules applicable to COBRA Continuation Coverage.

CONTINUATION OF OTHER COVERAGE

The following rules apply to the continuation of Plan coverage other than Health Coverage with respect to a leave of absence:

Whenever you are authorized to take a leave under FMLA, you will continue to receive coverage under Insurance Benefits (other than Health Coverage discussed above) and Non-Insurance Benefits only to the extent that there are sufficient monies allocated to your Insurance Account to pay premiums for such Insurance Benefits (or you make timely payments to the Employer/Plan Sponsor to cover such premiums) and monies allocated to your Non-Insurance Accounts to provide Non-Insurance Benefits.

Whenever you are authorized to take a leave of absence other than FMLA, you will continue to receive coverage under Insurance Benefits (other than Health Coverage discussed above) and Non-Insurance Benefits only to the extent that there are sufficient monies allocated to your Insurance Account to pay premiums for such Insurance Benefits and monies allocated to your Non-Insurance Accounts to provide Non-Insurance Benefits.

When you return to work after a FMLA leave, your Plan coverage will be reinstated without any penalty, regardless of whether you continued coverage while you were on FMLA leave. If you do not return to work after a FMLA leave, you may be entitled to continue your Health Coverage as described below in the section entitled *COBRA Continuation Coverage*.

When you return to work after a non-FMLA leave and you did not continue your coverage while on leave, your coverage may be reinstated, subject to any proof of good health requirements, pre-existing condition exclusions or other limitations applicable to reinstatement coverage. If you do not return to work after your leave, you may be entitled to continue your Health Coverage as described below in the section entitled *COBRA Continuation Coverage*.

Under no circumstances will FMLA leave exceed the maximum 12-week period discussed above. For more information about your rights under FMLA, contact the Employer/Plan Sponsor.

Military Leave Requirements

Under the Uniformed Services Employment and Reemployment Act of 1994, an employee on military leave and his or her eligible Dependents may elect to continue Health Coverage for up to 18 months following the employee's leave date or, if shorter, the employee's period of military leave. If an employee's leave is 31 days or less, the employee is only required to pay the Employee Contribution he or she would have paid as an active employee. If the employee's military leave is longer, he or she must pay 102% of the cost of his or her Health Coverage.

If you do not continue Health Coverage during your military leave and you return to employment with the Employer/Plan Sponsor at the end of such leave, you and your Dependents will have Health Coverage reinstated without exclusions or waiting periods that would not have been imposed had Health Coverage not been terminated. This rule does not apply to any illness or injury incurred or aggravated during your military service.

COBRA Continuation Coverage

If you, your spouse, or your Dependent child lose Medical, Dental or Vision Benefit coverage ("Health Coverage") under the Plan due to a "qualifying event," you and/or they may be able to continue coverage under the by enrolling and paying the applicable premium.

Employer/Plan Sponsors who generally employ 20 or more employees must comply with the Federal law commonly known as "COBRA" which requires that this opportunity be provided to "qualified beneficiaries." Employer/Plan Sponsors who generally employ fewer than 20 employees must comply with their State law providing for continuation coverage. Because the rules provided under Federal and New York State continuation laws are very similar, this SPD uses the term "COBRA" to apply to either law.

Qualifying Events

If the event is your termination of employment with the Employer/Plan Sponsor or a Participating Affiliate or your reduction in work hours, then you, your covered spouse, and/or your covered Dependent children may continue your Health Coverage for up to 18 months by enrolling within 60 days following the later of the date that the Coverage normally ends or the date on which you are given notice of your eligibility for COBRA. For purposes of COBRA, you, your covered spouse and/or Dependents are referred to as "qualified beneficiaries." A child born to, or placed for adoption with, a former employee during his or her COBRA coverage period may be enrolled in COBRA coverage within 31 days after the birth or adoption. The child will be treated as a qualified beneficiary eligible for COBRA coverage from the date of the qualifying event. If your Employer/Plan Sponsor is subject to the Federal COBRA law, COBRA coverage is not available if the reason your employment is terminated is gross misconduct.

COBRA coverage may be continued for an additional 11 months, for a total of 29 months, for qualified beneficiaries who are determined to have been disabled under the Social Security Act at any time during the first 60 days of their COBRA coverage if their COBRA coverage resulted from a termination or reduction in work hours. To qualify for this additional period of coverage, notification must be given to the Employer/Plan Sponsor within 60 days after the determination date of the disability (by the Social Security Administration) and before the end of the initial 18 months of coverage.

If the "qualifying event" is your death, your becoming divorced or legally separated or your becoming entitled to Medicare, then your covered spouse and/or Dependent child may continue coverage for up to 36 months if they notify the Employer/Plan Sponsor within 60 days following the event and enroll within 60 days following the later of the date that coverage normally ends or the date on which the company gives notice of eligibility for COBRA.

If the "qualifying event" is your covered Dependent child ceasing to be eligible for coverage under the Plan (for example, because he or she aged out), then your Dependent child may continue coverage for up to 36 months if the Employer/Plan Sponsor is notified of the cessation within 60 days following the event and your child enrolls within 60 days following the later of the date that coverage normally ends or the date on which the company gives notice of eligibility for COBRA.

Special COBRA rules apply to retired employees and their covered Dependents if the Employer/Plan Sponsor becomes involved in a Title 11 bankruptcy proceeding. If this event ever occurs, these persons will be notified of their COBRA rights at that time.

Enrollment in COBRA coverage

The Employer/Plan Sponsor will mail the COBRA coverage enrollment materials to you, your spouse and/or your Dependent(s), as appropriate, after it receives notice of the "qualifying event". If enrollment is completed within the 60-day limit described above and the applicable premium is paid, coverage will become effective as of the termination date of the original coverage. No evidence of insurability is required. Upon enrollment the Employer/Plan Sponsor will provide additional information and instructions.

Paying for Your COBRA Coverage

The applicable premium for COBRA coverage is 102 percent of the Plan's group rates for the full cost of the coverage elected. The first payment is due 45 days after enrollment. Payment is due retroactive back to the date of the termination of the original coverage. Under Federal law, the cost of coverage during the 11-month period of extended coverage due to a qualified beneficiary's disability under the Social Security Act will be 150% of the applicable premium if the disabled person is part of the family group covered by COBRA or 102% if the disabled person is not part of the family group. Under New York State law, the cost of coverage during the 11-month period of extended coverage due to a qualified beneficiary's disability under the Social Security Act will be 150% of the applicable premium.

Premiums for COBRA coverage must be paid on an after-tax basis in accordance with procedures specified by the Employer/Plan Sponsor.

Changing COBRA Coverage

You can change your coverage option (single, two-person, family) if you have a Change In Status event (for example, change from single to two-person coverage upon marriage) provided that you notify the Employer/Plan Sponsor within 31 days of the event. You can make other changes in your coverage during an Annual Enrollment Period. The Employer/Plan Sponsor will provide you with information on available coverage options prior to the Annual Enrollment Period.

Termination of COBRA Coverage

COBRA coverage automatically ends 18, 29, or 36 months, whichever is applicable, following the date of an enrolled individual's qualifying event. However, coverage may end before this scheduled time if the enrolled individual:

- cancels coverage;
- fails to pay the required premium;
- first becomes, after the date of his or her COBRA election, covered under another group health care plan, even if the other plan contains a pre-existing condition limitation, so long as that limitation does not apply to the qualified beneficiary;
- first becomes, after the date of his or her COBRA election, entitled to Medicare;

- is no longer disabled (as determined under the Social Security Act in the case of an individual whose coverage was extended beyond 18 months due to disability); or
- if the Employer/Plan Sponsor and all its affiliated companies cease to provide any health care coverage.

When your COBRA coverage applicable to your Medical Benefits under the Plan ends, you may be entitled to convert your group coverage for Medical Benefits to individual coverage. You may also convert your coverage for Medical Benefits under the Plan to individual coverage if you decide not to elect COBRA coverage. For more information on how to convert your coverage for Medical Benefits, you should review the next section of this SPD entitled *Conversion Privilege*.

Conversion Privilege

You may be able to convert your coverage under the Plan for Medical Benefits and/or Employee Life Insurance Benefits to an individual insurance policy when your coverage (or, in the case of Medical Benefits, your COBRA coverage) for such Benefits ends. The Insurance Contract applicable to a Benefit determines whether this conversion privilege is available with respect to the Benefit.

Generally a covered person must exercise his or her conversion right within 31 days of his or her loss of the Benefit coverage. The Insurance Company will determine the benefits to be provided under and the premiums for its individual insurance policies.

This conversion privilege is completely separate from a covered person's right to elect the COBRA coverage described above. If you are interested in converting your Medical Benefit coverage and/or Employee Life Insurance Benefit coverage and do not receive information about your conversion rights shortly after your coverage ends, you should contact the Employer/Plan Sponsor and the Insurance Company immediately.

CONTRIBUTIONS UNDER THE PLAN

Employer/Plan Sponsor Contributions

The Employer/Plan Sponsor pays for the cost of coverage under the Employer/Plan Sponsor Pay Benefits. The Employer/Plan Sponsor Contributions made on your behalf are paid to the Trustee under the Trust and allocated to one or more accounts established for your exclusive benefit. Contributions allocated to your Insurance Account(s) will be used to pay premiums for Insurance Benefits that are Employee Pay Benefits. Contributions allocated to your Non-Insurance Account will be used to pay Non-Insurance Benefits directly to you from the Trust.

If you do not work enough hours, the Employer/Plan Sponsor Contributions may not be enough to pay the full premium for an Insurance Benefit. In that case, the Employer/Plan Sponsor may require you to complete a "Stand-by Agreement for Prevailing Wage Employees" (included in the Election Form) which would require you to make contributions toward the cost of the Benefit in order to continue receiving coverage.

HOW TO FILE A CLAIM FOR BENEFITS

Insurance Benefits

A claim for payment under an Insurance Benefit must be filed with the Insurance Company that underwrites the Benefit in the manner and within the time provided in the Insurance Contract that governs that Benefit.

Note that the Insurance Contract that governs an Insurance Benefit may include limitations on the amount of cash payment that will be made and may require in the case of Medical Benefits, that the receipt of medical services be pre-approved before any cash payment or the maximum cash payment will be paid.

Non-Insurance Benefits

A claim for a Non-Insurance Benefit must be filed with the Administrator in the manner and within the time indicated in *Appendix B - Non-Insurance Benefits.*

Claims Procedure

Each Insurance Company, with respect to the Insurance Benefit that it provides, and the Employer/Plan Sponsor with respect to all Non-Insurance Benefits, generally has 90 days to make a decision on your claim after it receives the claim for payment. Under special circumstances, the Insurance Company or the Employer/Plan Sponsor may require up to an additional 90 days to make a decision on your claim.

If your claim is allowed, you will be notified of who has been paid and the amount that has been paid. All Benefits are paid as described below in the section of the SPD entitled **PAYMENT OF BENEFITS**. If your claim is denied in whole or in part, you should receive a notice setting forth the following information:

1. The specific reason or reasons for the denial of all or any portion of the claim;

2. The specific provisions of the Insurance Contract or other Plan document on which the denial is based;

3. A description of any additional material or information necessary for you to perfect the claim, and an explanation as to why such information or material is necessary; and

4. Information as to how you may submit the claim for review.

If you do not receive a decision after the 90-day period referred to above (180 days under special circumstances), you should consider the claim denied. You may appeal the denial by following the review

procedure described below in the section of this SPD entitled ***HOW TO APPEAL A DENIED CLAIM***.

PAYMENT OF BENEFITS

All payments with respect to Insurance Benefits provided under the Plan will be made to the health care provider or you in accordance with the applicable Insurance Contract.

All payments with respect to Non-Insurance Benefits will be made to you.

If any person entitled to receive a benefit payment under the Plan is, in the opinion of the payor (that is, the Insurance Company or the Employer/Plan Sponsor), legally, physically or mentally incapable of giving a valid receipt and discharge for any payment due him, the Insurance Company or the Employer/Plan Sponsor may have the payment, or any part thereof, made to such other person (or persons or institution) whom it reasonably believes is caring for or supporting such payee, unless it has received due notice of a claim therefore from a duly appointed guardian or other legal representative of such person. Any such payment will be a payment for the account of such person and will, to the extent thereof, be a complete discharge of any liability under the Plan to such person.

The Insurance Company or the Employer/Plan Sponsor may withhold the payment of any amount that shall be payable in accordance with the provisions of the Plan to a person under legal disability until a representative of such person competent to receive such payment is duly appointed.

NOTE: Any person who receives money from the Plan or an Insurance Company to which he or she is not entitled will be required to reimburse the Plan or Insurance Company, as applicable. The Plan or Insurance Company reserves the right to take legal action against such person to recover the incorrect payment.

HOW TO APPEAL A DENIED CLAIM

If you do not agree with the denial or partial denial of your claim or if you have any questions concerning your claim, you are encouraged to contact the Insurance Company (in the case of an Insurance Benefit) or the Employer/Plan Sponsor (in the case of a Non-Insurance Benefit). The addresses and phone numbers are supplied in the appendices of this SPD.

If you want a formal review of a denied claim under an Insurance Benefit that was submitted to an Insurance Company, you must contact the Insurance Company for information regarding its review procedures.

If you want a formal review of a denied claim under a Non-Insurance Benefit, you must write to the Employer/Plan Sponsor stating that you are requesting an official review of your claim and the reason(s) why you do not agree with the denial or partial denial of your claim. Telephone inquiries will not be considered a request for an official review of a denied claim.

When you request a review, you may designate a representative to act for you in the review procedure. To designate a representative, simply have that person sign a statement that he or she has been designated by you to be a representative. You must sign the statement and print your name under your signature. Your written designation of a representative is necessary to protect against disclosure of information about you except to your authorized representative.

Your written request must be made no later than 60 days after you receive notice of a denial or partial denial. During the 60 days, you or your representative may review the documents that directly affect your claim. If you wish, you or your representative may submit written issues, comments, and additional justification as to why the claim should be allowed.

Your appeal will be reviewed and you will be sent a written decision within 60 days from the date of your request for review. In case of special circumstances, you will be notified of the need for an additional 60 days to review your claim. The written decision will contain the reasons for the decision and references to the pertinent Plan provisions upon which the decision is based. If for some reason you do not receive a written decision within the 60-day period, or within the 120-day period where you have been given notice that more time is needed, the claim is considered denied. Any decisions on review will be final.

If you decide to start a legal action against the Plan with respect to a denied claim, you must first use the appeal process available under the Plan with respect to the claim. If the claim is for an Insurance Benefit, you must comply with any time limits for taking legal action that are described in the applicable Insurance Contract. If no such time limit appears in the Insurance Contract, or the claim is for a Non-Insurance Benefit, you must begin the action within the longer of: (1) 12 months from the date that you were notified of the final appeal decision denying the claim, or (2) 24 months from the date that the covered person received the services to which the claim pertains. Any legal action started without first complying with this paragraph will be barred by law.

SPECIAL RULES APPLICABLE TO HEALTH BENEFITS

This section of the SPD describes several rules that apply only to Medical Benefits, Dental Benefits and Vision Benefits ("Health Coverage") under the Plan. Some of these rules apply only to certain kinds of Health Coverage; others apply only to Employer/Plan Sponsors who have a specified minimum number of employees. Therefore, you should keep in mind what Health Coverage you have and the size of the Employer/Plan Sponsor and its Affiliates when

reviewing this section to determine which rules apply to your Health Coverage.

Pre-existing Condition Limitation

Applies only to Medical Benefits, and to Dental or Vision Benefits (if any) that are provided under the same Insurance Contract as Medical Benefits.

Depending on the Medical Benefits coverage option you have under the Plan, certain services may not be covered even if they are medically necessary. This is because some options exclude services that constitute "pre-existing conditions." A pre-existing condition is a condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on a covered person's enrollment date in the Plan. By law, pregnancy is not considered a pre-existing condition.

If your Medical Benefits coverage option contains a pre-existing condition exclusion, any expenses related to a pre-existing condition, or any complications of a pre-existing condition, which happened after you or your Dependent becomes covered under the Plan will not be paid until he or she has been continuously covered under the Plan for a specified time period (commonly referred to as the "exclusion period"). The Insurance Contract applicable to your coverage option should provide a more detailed explanation of any exclusion periods that may apply to you. A covered person who has a pre-existing condition will not be covered for the condition during the exclusion period UNLESS such exclusion period is reduced by "creditable coverage" (as defined below) received by the person prior to his or her coverage under the Plan.

Creditable coverage used to reduce a pre-existing condition exclusion includes prior health coverage under any type of comprehensive health program, including a group health plan (whether insured or uninsured and including COBRA coverage), Medicare, Medicaid, and military-sponsored health care programs. You must submit proof of your prior coverage credited against your pre-existing condition exclusion period. Generally, your proof will be in the form of a certificate of prior health coverage furnished to you by the insurer and/or Employer/Plan Sponsor providing the prior coverage. After you submit your proof, the Insurance Company underwriting your coverage will determine within a reasonable period of time what reduction, if any, is to be made to your exclusion period and notify you of its determination. If you do not agree with the determination, you may appeal it by following the Plan's appeal procedure used for claims administration described in the section of this SPD entitled ***HOW TO APPEAL DENIED CLAIMS***. If you have additional questions regarding this aspect of the Plan, you should contact the Employer/Plan Sponsor.

Breast Reconstruction and Related Coverage

Applies only to Medical Benefits.

Under a federal law known as the "Women's Health and Cancer Rights Act of 1998", group health plans and health insurance issuers that provide mastectomy coverage must also cover the following services:

a. Reconstruction of the breast on which the mastectomy has been performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
c. Prostheses and treatment of any physical complications during all stages of the mastectomy, including lymphedemas.

This coverage must be provided in consultation with the covered person and the attending physician and will be subject to the same annual deductible and coinsurance provisions applicable to other benefits under the covered person's coverage option.

Newborns' and Mothers' Health Protection Act

Applies only to Medical Benefits.

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. 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Rules for Choosing Medicare or Plan Coverage

Applies only to Medical Benefits.

The following rules apply in situations in which an individual has a choice of electing either Medicare or Medical Benefit coverage under the Plan as their primary health care coverage:

THE WORKING AGED RULE

Applies only to plans of Employer/Plan Sponsors who generally employ 20 or more employees.

When you or your spouse become eligible for Medicare due to the attainment of age 65, you or your spouse may still be entitled to the hospital and medical benefits provided under this Plan. To qualify for Medical Benefits under the Plan, you must be age 65 or over and still an Employee of the Employer/Plan Sponsor or a Participating Affiliate who is eligible for Plan coverage. Your spouse qualifies for these Benefits if he or she is age 65 or over and you are an Eligible Employee who is employed by the Employer/Plan Sponsor or a Participating Affiliate. Under these

circumstances, you or your spouse have the option of choosing as primary coverage either Medical Benefit coverage under the Plan or Medicare benefits.

If you choose or your spouse chooses Medical Benefits under the Plan as primary coverage, the Plan will pay the portion of your incurred expenses that are normally covered by the option you elect. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are covered expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the Plan. If the expenses are not covered by the Plan option you elect but are Medicare-covered expenses, then Medicare will process its payment of the expenses as if you do not have Medical Benefit coverage under the Plan.

When Medical Benefit coverage under the Plan is elected as primary coverage for an aged person, the start of Medicare Part B coverage for the aged person may be deferred, without penalty, for up to eight full months after such person's Medical Benefit coverage terminates. Your local Social Security office can provide you with more detailed information on how this deferral works.

If you choose Medicare benefits as primary coverage, you, your spouse and your Dependent children will no longer be eligible for Medical Benefits coverage under the Plan. If your spouse chooses Medicare coverage as primary coverage, your spouse will no longer be eligible for Medical Benefits coverage, but you and your Dependent children may still continue such coverage under this Plan.

THE DISABILITY RULE

Applies only to plans of Employer/Plan Sponsors who generally employ 100 or more employees.

If you are or your covered Dependent is eligible for Medicare by reason of disability due to a condition other than end-stage renal disease, you or your Dependent have the option of choosing the Medical Benefit coverage provided under the Plan or Medicare benefits as primary health coverage for the period that you are an employee of an Employer/Plan Sponsor and are eligible for Plan coverage. When Medical Benefit coverage under the Plan is elected as primary coverage, the start of Medicare Part B coverage may be deferred, without penalty, until the last day of the eighth consecutive month after the first day of the month in which Plan coverage terminates. Your local Social Security office can provide you with more detailed information on how this deferral works.

If you are a New York State resident, you may have the right to continue coverage under a non-Medicare HMO option even though you are entitled to Medicare coverage. Penalties may apply if you defer your Medicare Part B coverage as a result of this election. Your Insurance Company can provide you with more information regarding this election.

If you choose Medicare coverage as primary coverage, you, your spouse and your Dependent children will no longer be eligible for Medical Benefits coverage under the Plan. If your Dependent chooses Medicare coverage as primary coverage, your Dependent will no longer be eligible for Medical Benefits coverage under the Plan but you and your other Dependents may still continue such coverage under this Plan.

THE END-STAGE RENAL DISEASE RULE

Applies only to plans of Employer/Plan Sponsors who generally employ 20 or more employees.

If you become or your covered Dependent becomes eligible for Medicare due to end-stage renal disease ("ESRD"), you or your Dependent may have the option of choosing Medical Benefits coverage under the Plan or Medicare benefits as primary health coverage for a period not to exceed 30 months generally beginning the first day of the month of eligibility or entitlement to Medicare due to ESRD. Because an ESRD patient can have up to a three-month wait to obtain Medicare coverage, the Plan's primary payment responsibility may vary up to three months. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the Plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply. The Employer/Plan Sponsor or the Insurance Company underwriting your Medical Benefits can provide you with more detailed information on how this rule works.

Policy Statement of Health Care Fraud

Applies to Medical Benefits, Dental Benefits and Vision Benefits.

Health care plan fraud is a felony that can be prosecuted. Any employee or former employee who willfully and knowingly engages in an activity intended to defraud the Plan will face disciplinary action that may include the termination of employment and may result in prosecution.

Documentation of Group Health Plan Coverage

Applies only to Medical Benefits, and to Dental or Vision Benefits (if any) that are provided under the same Insurance Contract as Medical Benefits.

A federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that any person whose group health plan coverage ends (for instance, if he or she terminates employment or if a covered Dependent reaches the maximum age allowed under the applicable Plan coverage option) must receive a "Certificate of Group Health Plan Coverage." This certificate identifies the plan(s) under which the person (and his or her Dependents) had coverage during the 24 months prior to the date coverage ended, and any breaks in coverage.

HIPAA limits the circumstances under which health care coverage may be excluded for medical conditions

that are present before you enroll in a plan (called a "pre-existing condition exclusion"). This may be important to you if you or your Dependents ever apply for coverage under another Employer/Plan Sponsor's group health plan or other kinds of health insurance.

HIPAA states that a pre-existing condition exclusion generally may not be imposed for more than 12 months when you first enroll in a plan that has such an exclusion, unless you are considered by the new plan to be a late enrollee (someone who enrolls after his or her initial enrollment eligibility date), in which case the pre-existing condition exclusion may apply for up to 18 months. However, the 12- or 18-month period must be reduced by your period of prior health coverage. For instance, if your new plan has a 12-month pre-existing condition exclusion, but you were covered under this Plan for the prior 12 months, then your new plan could not apply its pre-existing condition exclusion to you for any period. The certificate you will receive when your coverage ends can be used to demonstrate to your new health plan that you had prior health coverage under this Plan.

If you are going to become covered under a group health plan, other than one sponsored by the Employer/Plan Sponsor, check with your new plan administrator to see if your new health plan excludes coverage for pre-existing conditions, and if you need to provide a certificate or other documentation of your previous coverage. If your Dependent needs a separate certificate in his or her own name, he or she may obtain one by contacting the Employer/Plan Sponsor. You or your Dependent may also request a duplicate certificate by contacting the Employer/Plan Sponsor within two years following the end of your Plan coverage. Because HIPAA includes similar requirements for Insurance Companies to provide certificates, you may also request one or more certificates from your former Insurance Company(s) when your coverage with the Insurance Company(s) ends.

PLAN AMENDMENT OR TERMINATION

The Employer/Plan Sponsor reserves the right to reduce or increase the level of benefits offered under the Plan, or to reduce or increase required Employee Contributions, and to amend or terminate the Plan at any time for any reason, according to the terms of the Basic Plan Document. The Basic Plan Document is available for review during normal business hours by contacting the Employer/Plan Sponsor.

ERISA STATEMENT

The following statement explains your legal rights and is supplied in accordance with federal regulations.

As a participant in this 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:

° Examine, without charge, at the Employer/Plan Sponsor’s office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

° Obtain, upon written request to the Employer/Plan Sponsor, copies of documents governing the operation of the Plan, including insurance contracts, copies of the latest annual report (Form 5500 Series) and a copy of an updated SPD. Your Employer/Plan Sponsor may impose a reasonable charge for the copies.

° Receive a summary of the Plan's annual financial report. The Employer/Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

° Continued health care coverage for you or your Dependent if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependent may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

° The reduction or elimination of any exclusionary periods of coverage for preexisting conditions under this Plan’s Health Benefits, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your other group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA 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.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plans. 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 any Employer/Plan Sponsor 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. If your claim for a Plan benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Employer/Plan Sponsor, as Plan administrator, to provide the

materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent to you because of reasons beyond the control of the Employer/Plan Sponsor. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

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, you should contact the nearest office of the Pension and Welfare Benefit Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

GLOSSARY

The following are the meanings of some terms used in this Summary Plan Description:

"Actively Employed" means, with respect to benefits other than Medical Benefits, and Dental and/or Vision Benefits provided under the same Insurance Contract as Medical Benefits, performing the usual duties of your job at your Employer/Plan Sponsor's worksite to which you are assigned. The Actively Employed rule does not apply to Medical Benefits, or to Dental and/or Vision Benefits provided under the same Insurance Contract as Medical Benefits.

"Adoption Agreement" means a document that the Employer/Plan Sponsor completes and signs in order to adopt the Plan and to select the Benefits available through the Plan

"Basic Plan Document" means a document that contains terms of the Plan in addition to those set forth in the Adoption Agreement and this SPD. The Basic Plan Document is the same for all Employer/Plan Sponsors who adopt the Master Plan.

"Benefit" means an Insurance Benefit or a Non-Insurance Benefit that is available under the Plan.

"Combination Benefit" means an Insurance Benefit for which the Employer/Plan Sponsor and the Employee share the cost of premiums for some or all coverage options.

"Dependent" means a spouse, child or other person who may be entitled to Health Coverage under the Plan. See the section of this SPD entitled ***Dependents Who Are Eligible to Participant***.

"Effective Date" means the date on which the Plan begins. The Effective Date is set forth in Appendix A of this SPD. It is the earliest date on which any benefit coverage can begin under the Plan.

"Election Form" means an agreement by an Eligible Employee wherein the Employee [1] indicates the Benefits that the Employee elects to receive from the Insurance Benefits available under the Plan, and [2] agrees to permit the Employer/Plan Sponsor to deduct Employee Contributions from the Employee's pay to cover the Employee's share of the cost of premiums for such Benefits.

"Election Period" means the period during which an Eligible Employee can make or change an election beginning on the next following Entry Date. The Employee makes his or her election by completing an Election Form and submitting it to his or her Employer/Plan Sponsor during the Election Period. Election Periods occur (A) after an Employee satisfies the eligibility requirements for participation in the Plan, (B).

"Eligible Employee" means an employee of the Employer/Plan Sponsor or a Participating Affiliate who is a member of the class of employees covered by the Plan.

"Employee After-tax Contributions" means, with respect to an Insurance Benefit, the amount of compensation that an Eligible Employee elects to apply, on an after-tax basis, toward the cost of the Benefit, or with respect to an alternate recipient under a Qualified Medical Child Support Order or a qualified beneficiary with COBRA Continuation Coverage, the amount of cash that such person must pay for the Health Coverage he or she has elected.

"Employee Before-tax Contributions" means, with respect to an Insurance Benefit, the amount of compensation that an Eligible Employee elects to apply, on a before-tax basis, toward the cost of the Benefit.

"Employee Contributions" means Employee Before-Tax Contributions and/or Employee After-Tax Contributions.

"Employer/Plan Sponsor Contributions" means contributions made with an Eligible Employer/Plan Sponsor's own funds, that is, contributions which are not deducted from the Employee's pay on either a before-tax or an after-tax basis.

"Employer/Plan Sponsor Pay Benefit" means a Non-Insurance Benefit or an Insurance Benefit where

all of the premiums are paid with Employer/Plan Sponsor Contributions.

"Entry Date" means any one of the Entry Dates listed in Appendix A of this SPD. Ordinarily, coverage under any Benefit available under the Plan must begin on an Entry Date.

"Health Coverage" means Medical Benefit, Dental Benefit and/or Vision Benefit coverage under the Plan.
"Insurance Account" means an account maintained under the Trust for the exclusive benefit of an Eligible Employee from which premiums for Insurance Benefits are payable.

"Insurance Benefits" means any of the following benefits that the Employer/Plan Sponsor elects to make available under the Plan: Medical Benefits, Dental Benefits, Vision Benefits, Employee Life Insurance, Accidental Death & Dismemberment Insurance, Long Term Disability Insurance, and Short-Term Disability Insurance.

"Insurance Contract" means the contract, any riders, and any other document that, taken together, set forth the terms and provisions of an Insurance Benefit provided by an Insurance Company.

"Insurance Company" means an insurance carrier or health maintenance organization that underwrites an Insurance Benefit offered under the Plan.

"Master Plan" means the GMR Associates Prevailing Wage Master Plan consisting of the Trust Agreement, the Basic Plan Document, the form of Summary Plan Description and the form of Adoption Agreement.

"Non-Insurance Account" means an account maintained under the Trust for the exclusive benefit of an Eligible Employee from which Non-Insurance Benefits are payable.

"Non-Insurance Benefits" means any of the following benefits that the Employer/Plan Sponsor elects to make available under the Plan: Vacation/Holiday/Training/Sick Pay Benefits, Job Training Benefits and Supplemental Unemployment Benefits.

"Plan" means the welfare benefit plan adopted by the Employer/Plan Sponsor which is summarized in this SPD. The terms of the Plan are contained in several documents each of which is part of the Plan. These documents are this SPD, the Adoption Agreement, the Basic Plan Document, the Insurance Contracts and the Trust Agreement.

"Process Date" means the date on which an Election Form is received by the Third Party Administrator provided the Election Form was returned by the Employee to the Employer/Plan Sponsor during an Election Period.

"Qualified Medical Child Support Order" or ***"QMCSO"*** means a child support decree or order issued by a court (or through a state administrative process that has the force and effect of law under applicable state law) requiring you to support or provide health care coverage to the child named in the order and includes certain information concerning such coverage. The Employer/Plan Sponsor will determine whether any child support order or decree that the Plan receives constitutes a QMCSO. Except for QMCSOS, no child is eligible for Plan coverage, even if you are required to provide coverage for that child under the terms of a separation agreement or court order, unless the child is an eligible Dependent as described above.

"Third Party Administrator" means GMR Associates, Inc. or its successor.

"Summary Plan Description" or ***"SPD"*** means this Summary Plan Description.

"Trust Agreement" means the agreement between the Third Party Administrator and the Trustee which establishes the Trust.

"Trustee" means the person identified as the Trustee in Appendix A of this SPD.

APPENDIX A - ADDITIONAL INFORMATION ABOUT THE PLAN

Plan Name:	Welfare Benefits Plan for the employees of Empire State Merit Apprenticeship Alliance, Inc.
Plan Number:	**510**
Plan Year:	**July 1 to June 30**
Plan Effective Date:	**10/1/2007**
Entry Dates:	New Employee: The first day of the first pay period beginning on or after the day that the Employee becomes an Eligible Employee. Rehired Employees: Same as for new Eligible Employees. New or Rehired Employee: N/A After Change In Status: N/A
Employer/Plan Sponsor/Plan Sponsor:	Empire State Merit Apprenticeship Alliance, Inc. 109 Twin Oaks Drive, Syracuse, NY 13206 EIN 20-8482142
Plan Administrator:	Empire State Merit Apprenticeship Alliance, Inc.
Participating Affiliates:	None
Third Party Administrator:	GMR Associates, Inc. 300 Buell Road Rochester, New York 14624 Telephone: 585-429-1330
Plan Trustee:	Manufacturers and Traders Trust Company, Trust Dept One M&T Plaza, 8th Floor Buffalo, NY 14203
Agent for Service of Legal Process:	Empire State Merit Apprenticeship Alliance, Inc.
Type of Plan and Funding Medium:	Welfare plan providing Insurance Benefits and Non-Insurance Benefits. All Insurance Benefits are insured with Insurance Companies. Premiums for such insurance are paid from monies contributed to the Trust. All Non-Insurance Benefits are paid from monies allocated to a Participant's Non-Insurance Account under the Trust.

APPENDIX B – DESCRIPTION OF NON-INSURANCE BENEFITS

Set forth a detailed description of each Non-Insurance Benefit offered under the Plan including the conditions for eligibility, how claims are made for payments, tax effects and limitation on the amount of Benefit payments.

BENEFIT FORMAT	***ELIGIBILITY LIMITS***	***SUBJECT TO TAX***	***CLAIM***
Holiday	*	*Yes*	*Notify Third Party Administrator/Administrator*
Vacation	*	*Yes*	*Notify Third Party Administrator/Administrator*
Sick	*	*Yes*	*Notify Third Party Administrator/Administrator*
Personal	*	*Yes*	*Notify Third Party Administrator/Administrator*
Job Training	*	*Yes*	*Notify Third Party Administrator/Administrator*
Supp Unemp	*Layoff Status* *	*Yes*	*Notify Third Party Administrator/Administrator*
Supp Workers Comp	*Layoff Status* *	*Yes*	*Notify Third Party Administrator/Administrator*

* Eligibility and Limits are determined by parameters set forth in the company's Employee's Benefit Handbook.