SUMMARY PLAN DESCRIPTION (SPD)
Employee Retirement Income and Security Act of 1974

This **wrap document** is being provided to help clients obtain a legally sufficient Summary Plan Description (SPD) under the Employee Retirement Income and Security Act of 1974 (ERISA). **It is to be used in conjunction with an Insurance Summary or Insurer's explanation of benefits to create a Summary Plan Description**.

[THIS PAGE IS INSTRUCTIONAL AND DOES NOT NEED TO BE PROVIDED TO PARTICIPANTS]

SPD WRAP DOCUMENT – PLEASE READ

Dear Employer:

The Employee Retirement Income and Security Act of 1974 (ERISA) requires that the sponsors of group plans comply with certain disclosure requirements including the requirement to supply employees with a Summary Plan Description (SPD). To be legally compliant with ERISA, an SPD must have certain statutorily-defined specific information about the underlying plan that is specific to the employer and is not contained in most Certificates of Coverage provided by Insurers. So, your SPD must include one or more documents you prepare and adopt in addition to the documents provided by an insurer.

When customized with your employer-specific information the resulting document could be used in conjunction with, for example, a Certificate of Coverage, Member Payment Summary, and Provider & Facility Directory supplied by your insurer to create an SPD. The necessary information contained in the final document will vary depending on the specific design and administration of your plan and the existence of other plan documents.

Moreover, under ERISA the responsibility for issuing an SPD rests with you, the Employer/Plan Administrator, and not with PrimePay. PrimePay is not the ERISA Plan Administrator and is not responsible for your compliance with ERISA outside of the terms of the ERISA Compliance Services Agreement (*e.g.*, distributing your Summary Plan Description).

Thank you,

PrimePay ERISA Compliance Services

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Who must receive an SPD?

SPDs must be provided to the following parties:

- Covered participants - Department of Labor regulations specifically exclude plan beneficiaries (i.e. spouses and dependents) from the distribution requirement;
- A child added to the plan through a Qualified Medical Child Support Order and his or her parent-guardian
- Spouse and/or dependent(s) of a deceased retiree (if your plan provides retiree coverage)
- COBRA Qualified Beneficiaries (including the guardian of an incapacitated COBRA Qualified Beneficiary)

What methods can you use to distribute SPDs?

SPDs must be furnished in a way "reasonably calculated to ensure actual receipt of the material." The Department of Labor has issued regulations approving the following methods:

- First-Class Mail - Delivery by first-class mail is specifically approved so long as the mailing list is comprehensive and up to date.
- Second and Third-Class Mail - Second and third-class mail delivery is specifically approved so long as the mailing list is comprehensive and up to date, and return/forwarding postage is guaranteed and address correction is requested.
- Insert in Company Publication - SPDs can be delivered as a special insert in a union or company publication so long as the mailing list is comprehensive and up to date, there is a notice prominently displayed on the cover stating that an SPD is contained in that issue, and steps are taken to insure delivery to participants who may not be on the mailing list.
- By Hand - Delivery of SPDs by hand at a worksite has been approved; however, you cannot merely place copies of the SPD in a location frequented by participants.
- By Electronic Means - Delivery of SPDs by electronic means is acceptable; however a number of Department of Labor requirements must be met. Please ask your legal counsel if you are able to meet these requirements. *See also*, Department of Labor, Employee Benefits Security Administration Technical Release No. 2011-03, Interim Policy on Electronic Disclosure Under 29 CFR 2550.404a-5, located at: http://www.dol.gov/ebsa/newsroom/tr11-03.html

How often must you distribute SPDs?

When your plan is established, a summary plan description must be provided to plan participants (covered employees) within 120 days of the plan's effective date. Because these documents may be created mid-year, best practice would include immediate distribution and every open enrollment thereafter. Thereafter, new participants must receive an SPD within 90 days of joining the plan. If you make a material change to the employer- specific information contained in the SPD Wrap, you will need to distribute a Summary of Material Modifications describing the change within 210 days after the end of the plan year in which the modification is adopted. If the modification is a material reduction in services or benefits, covered participants must be notified within 60 days of the date the modification is adopted.

In general, if there have been any plan amendments, the plan administrator must furnish an updated SPD every five years. Otherwise, an updated SPD must be furnished every 10 years even if no plan amendments have been made.

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Franklin LTC, LLC Employee Benefits Plan

Group Medical

Summary Plan Description

Amended and Restated As Of:

October 1, 2016

I. INTRODUCTION

This document contains a summary in English of your plan rights and benefits under your employer's employee benefit plan(s). If you have difficulty understanding any part of this booklet, contact the Plan Administrator identified below. This document is to be used in conjunction with the plan documents and insurance materials that are provided to you. These materials replace and supersede all other prior agreements between the Parties as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the Parties related to matters covered under the plan documents or the documents incorporated herein. If any provision of this document is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this document shall continue in full force and effect. The Plan Administrator has discretionary authority to interpret and administer, in its sole discretion, the terms of the plan and to make factual determinations.

Under the Employee Retirement Income Security Act (ERISA), each participant and beneficiary of an employer welfare benefit plan must be provided with a Summary Plan Description (SPD) which explains the terms, rights and benefits available to the plan, in a summary form. The coverage available under the plan is explained in more detail in the individual group contracts, certificates, and plan documents, however those documents on their own may not contain all the information that ERISA requires for summary plan descriptions (SPDs) or are not concise enough to be easily understood. This SPD "wrap document" is designed to meet the ERISA requirements and is to be used in conjunction with the plan summary booklets that are provided to you.

NOTE: The information contained herein is current as of October 2016.

Franklin LTC, LLC ("Employer") maintains the Franklin LTC, LLC Employee Benefits Plan ("Plan") for the exclusive benefit of its eligible employees and their eligible dependents. Benefits under the Plan are currently provided under group insurance contracts ("Group Insurance Contracts") entered into between the Employer and BlueCross BlueShield of Alabama known collectively throughout this document individually as "Insurance Carrier."

Plan benefits, including information about eligibility, are summarized in the documents issued by Insurance Carriers, copies of which are available from your Human Resources Department, free of charge. These documents together with this document constitute the Summary Plan Description required by ERISA. Capitalized terms not otherwise defined in this document are defined in the Certificate of Coverage.

II. SPECIFIC PLAN INFORMATION

Plan Name:	Franklin LTC, LLC Employee Benefits Plan
Type of Plan:	Group Medical
Plan Year:	January 1- December 31
Plan Number:	501

Employer / Plan Sponsor:	Franklin LTC, LLC 390 Underwood Road Russellville, AL 35653
Plan Funding and Type of Administration:	The plan benefits are fully insured. Benefits are provided under the Group Insurance Contract between the Employer and Insurance Carrier. Claims for benefits are sent to the Insurance Carrier, which is responsible for paying claims. Insurance Premiums are paid through mandatory employer contributions and employee payroll deductions.
Plan Sponsor's Employer Identification Number:	81-0817674
Plan Administrator:	Franklin LTC, LLC 390 Underwood Road Russellville, AL 35653 601-849-2294
Named Fiduciary:	Franklin LTC, LLC 390 Underwood Road Russellville, AL 35653 601-849-2294
Agent for Service of Process:	Benny Hubbard Franklin LTC, LLC 390 Underwood Road Russellville, AL 35653 601-849-2294 Service of process may also be made on the Plan Administrator.
Important Disclaimer:	Plan benefits are provided under Group Insurance Contracts between the Employer and Insurance Carriers and/or Service Agreements with a Third-Party Administrator. If the terms of this summary document conflict with the terms of the Group Insurance Contracts or Service Agreement, the terms of the Group Insurance Contracts or Service Agreement will control, unless superseded by applicable law.

III. ELIGIBILITY

Subject to any additional eligibility requirements for a component benefit program that are set forth in the plan documents identified in the Attachments, employee eligibility requirements are:

> You and your eligible dependents, are eligible to participate in the Plan if you are a full time employee working a minimum of 30 hours per week. You will become eligible the first of the month following 60 days from your date of employment.

During the Employer Waiting Period, you must work the specified minimum required hours except for paid time off and hours you do not work due to a medical condition, the receipt of healthcare, your health status or disability.

To determine whether your spouse and dependent children are eligible to participate in the Plan, please read the eligibility information contained in the documents issued by Insurance Carriers.

Franklin LTC, LLC (the "Employer") maintains the Franklin LTC, LLC Employee Benefits Plan ("the Plan") for the exclusive benefit of its eligible employees and their eligible dependents. Its purpose is to reward them by providing benefits for those eligible employees and their dependents and beneficiaries. The concept of this Plan is to allow employees to choose among different types of benefits based on their own particular goals, desires and needs.

Certain benefits under the Plan are currently provided under a group insurance contract entered into between the Employer and BlueCross BlueShield of Alabama (Medical**)** (Insurance Carrier).

Plan benefits, including information about eligibility, are summarized in the documents issued by the Insurance Carrier, copies of which are available from your Human Resources Department, free of charge. These documents together with this document constitute the Summary Plan Description required by the federal law known as the Employee Retirement Income and Security Act ("ERISA"). Capitalized terms not otherwise defined in this document are defined in the Certificates of Coverage.

The Plan will extend benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are your biological children. Also eligible is any child covered under a Qualified Medical Child Support Order (QMCSO) as defined by applicable law and determined by your Employer under its QMCSO procedures, a copy of which is available from your Human Resources Department, free of charge.

If eligible, you must complete an application form to enroll in the Plan or otherwise comply with your Employer's enrollment procedures.

Coverage will terminate if you no longer meet the eligibility requirements. Coverage may also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you submit false claims, etc. (See the Certificate(s) of Coverage or Service Agreement for more information.) Coverage for your spouse and dependents stops when your coverage stops. Their coverage will also stop for other reasons specified in the Certificate of Coverage.

IV. SPECIAL SITUATIONS & EXTENSION OF COVERAGE

A. Mid-year Benefit Changes

Generally, the benefits that you elect at open enrollment remain in effect through the entire Plan Year. However, you may be able to make certain mid-year changes to your post-tax benefits.

In addition, you may be able to make certain mid-year changes to your pre-tax benefits, provided the change meets standards set forth by the Internal Revenue Service. These changes, described below, are called status changes, and you must notify the Plan Administrator within 30 days of experiencing a status change event (or within 30 days or 60 days, as applicable, for a HIPAA special enrollment event, as described below).

B. Status Changes

You may be able to make changes to your **Medical** if you experience a mid-year status change and can provide sufficient documentation of the event to the satisfaction of the Plan Administrator. The following events are considered status changes:

- Change in legal marital status (such as marriage, divorce, death of spouse, legal separation and annulment);
- Change in number of dependents (such as birth, adoption, placement for adoption and death. *See also, HIPAA Special Enrollment, below.*);
- Change in employment status (such as termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, or a change in worksite that affects benefits eligibility);
- Beginning or returning from FMLA leave;
- Dependent satisfies or ceases to satisfy dependent eligibility requirements (such as due to age);
- Residence change (if the change affects benefits eligibility); and
- Commencement or termination of adoption proceedings.

Any status change must also satisfy Internal Revenue Service "consistency" rules, which generally require the status change to be on an account of and correspond with an event that affects benefits eligibility. This also means that the change you make to your coverage has to be consistent with the status change. Please contact the Plan Administrator for more information.

C. Other Changes

If any of the following events takes place mid-year, you may also be able to make a mid-year change to certain pre-tax benefits:

- Cost changes (such as significant increase or decrease of coverage costs);
- Significant coverage changes (such as significant restrictions or detrimental coverage changes, significant addition or significant improvement of a coverage option);
- Changes under another employer's plan (such as different open enrollment periods); or
- Loss of other group health plan coverage (such as loss of governmental or educational institution's coverage, state children's health insurance program (CHIP), or foreign government group health plan).

D. HIPAA Special Enrollments

If you experience one of the following HIPAA special enrollment events and notify the Plan Administrator within the timeframes indicated below, you may make medical plan elections mid-year, which would include enrolling a Dependent or Spouse:

- Acquisition of a new dependent (such as marriage, birth, adoption and placement for adoption, if notice is provided to the Plan Administrator within 30 days of the event);
- Loss of coverage under a group health plan (such as under a spouse's plan, including termination of employer contributions); or
- Gain or loss of eligibility under Medicaid or state children's health insurance program (CHIP) (if notice is provided no later than 60 days after the date of the event).

All HIPAA special enrollment events must meet the requirements under HIPAA regulations.

E. Family Medical Leave Act

Family and Medical Leave Act (FMLA)

If the Family Medical Leave Act (FLMA) applies to your Employer and you qualify for an approved family or medical leave of absence (as defined in the FMLA), eligibility may continue for the duration of the leave if required contributions are paid toward the cost of the coverage. Your Employer has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due date established by your Employer will result in the termination of coverage. Subject to certain exceptions, if you fail to return to work after the leave of absence, your Employer has the right to recover from you any contributions toward the cost of coverage made on your behalf during the leave, as outlined in the FMLA.

If coverage is terminated for failure to make payments while you are on an approved family or medical leave of absence, coverage for you and your eligible dependents will be automatically reinstated on the date you return to employment if you and your dependents are otherwise eligible under the plan. Any waiting period for pre-existing conditions or other waiting periods will not apply. However, all accumulated annual and lifetime maximums will apply.

If you do not return to work at the end of an FMLA leave, you may be entitled to elect COBRA Continuation Coverage, even if you were not covered under the Plan during the leave. Coverage continued under this provision is in addition to coverage described below under the section entitled "Continuation Coverage (COBRA)."

The Plan intends to comply with all existing FMLA regulations. If for some reason the information presented differs from actual FMLA regulations, the Plan reserves the right to administer the FMLA in accordance with such actual regulations.

F. Military Leave Coverage

The Uniformed Services Employment and Reemployment Rights Act (USERRA) establishes requirements that employers must meet for certain employees who are involved in the uniformed services.

As used in this provision, "Uniformed Services" means:

- The Armed Forces;
- The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (pursuant to orders issued under federal law);
- The commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or national emergency.

As used in this provision, "Service in the Uniformed Services" or "Service" means the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty training;
- Inactive duty training;
- Full-time National Guard duty;
- A period for which you are absent from your job for purpose of an examination to determine your fitness to perform any such duties;
- A period for which you are absent from your job for the purpose of performing certain funereal honors duty; and
- Certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

If you were covered under this Plan immediately prior to taking a leave for Service in the Uniformed Services, you may elect to continue your coverage under USERRA for up to 24 months from the date your leave for uniformed service began, if you pay any required contributions toward the cost of the coverage during the leave. This USERRA continuation coverage will end earlier if one of the following events takes place:

- You fail to make a premium payment within the required time;
- You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or
- You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, your contribution amount will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

Coverage continued under this provision runs concurrently with coverage described below under the section entitled "COBRA Continuation Coverage." If your coverage under the Plan terminated because of your Service in the Uniformed Services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA.

When coverage under this Plan is reinstated, all of the Plan's provisions and limitations will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the VA. (For complete information regarding your rights under USERRA, contact your Employer.)

The Plan intends to comply with all existing regulations of USERRA. If for some reason the information presented in the Plan differs from the actual regulations of USERRA, the Plan reserves the right to administer the plan in accordance with such actual regulations.

V. COBRA CONTINUATION COVERAGE

The following benefits are subject to COBRA continuation coverage: **Medical**

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under a group health plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under a group health plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under a group health plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under a group health plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

If this plan offers coverage to retirees and you are a retiree, you will become a qualified beneficiary if you will lose your coverage under a group health plan because of your employer's bankruptcy. If this plan does not offer retiree coverage, this qualifying event does not apply. The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Eligible Employee, or the Eligible Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Company must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events. For all other qualifying events (divorce or legal separation of you and your spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You should send this notice, in writing, describing the qualifying event, to the Plan Administrator. If you do not provide timely notice, you may not be eligible for COBRA coverage.

Note: To choose this continuation coverage, an individual must be covered under the Plan on the day before the qualifying event. In addition, your newborn child or child placed for adoption with you during a period of continuation coverage will remain eligible for continuation coverage for the remaining period of coverage even if you and/or your spouse terminate continuation coverage following the child's birth or placement for adoption.

Notification Requirements

Subject to the Plan Administrator being informed in a timely manner of the qualifying events described in the above paragraphs, the Plan will promptly notify you and other qualifying individual(s) of their continuation coverage rights. You and any applicable dependents must elect continuation coverage within 60 days after Plan coverage would otherwise end, or, if later, within 60 days of the notice of continuation coverage rights. Failure to elect continuation coverage within this 60-day period will result in loss of continuation coverage rights.

Trade Act of 2002

If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, then you will be provided with an additional 60 day enrollment period, with continuation coverage beginning on the date of such TAA approval.

Notice of Unavailability of Continuation Coverage

If the Plan Administrator receives a notice of a qualifying event from you or your dependent and determines that the individual (you or your dependent) is not entitled to continuation coverage, the Plan Administrator will provide to the individual an explanation as to why the individual is not entitled to continuation coverage. This notice will be provided within the same time frame that the Plan Administrator would have provided the notice of right to elect continuation coverage.

Maximum Period of Continuation Coverage

The maximum period of continuation coverage is 36 months from the date of the qualifying event, unless the qualifying event is your termination of employment or reduction in hours. In that case, the maximum period of continuation coverage is generally 18 months from the date of the qualifying event.

However, if a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of continuation coverage, continuation coverage for the qualifying individual and any non-disabled eligible dependents who are also entitled to continuation coverage may be extended to 29 months provided the qualifying individual or dependent, if applicable, notifies the Plan Administrator in writing within the 18-month continuation coverage period and within 60 days after receiving notification of determination of disability.

If a second qualifying event occurs (for example, your death or divorce) during the 18- or 29-month coverage period resulting from your termination of employment or reduction in hours, the maximum period of coverage will be computed from the date of the first qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

A special rule applies if the qualifying individual is your spouse or dependent child whose qualifying event was the termination or reduction in hours of your employment and you became entitled to Medicare within 18 months before such qualifying event. In that case, the qualifying individual's maximum period of continuation coverage is the longer of 36 months from the date of your Medicare entitlement or their otherwise applicable maximum period of coverage.

Cost of Continuation Coverage

The cost of continuation coverage is determined by the Employer and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102 percent of the Plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150 percent of the Plan's cost of coverage.

Premium payments for continuation coverage for you or your eligible dependent's "initial premium month(s)" are due by the 45th day after electing continuation coverage. The "initial premium month(s)" are any month that ends on or before the 45th day after you or the qualifying individual elect continuation coverage. All other premiums are due on the first of the month for which coverage is sought, subject to a 30-day grace period. Premium rates are established by your Employer and may change when necessary due to Plan modifications.

The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event. Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

When Continuation Coverage Ends

Continuation of coverage ends on the earliest of:

- The date the maximum continuation coverage period expires;
- The date your Employer no longer offers a group plan to any of its employees;
- The first day for which timely payment is not made to the Plan;
- The date the qualifying individual becomes covered by another group plan. However, if the new plan contains an exclusion or limitation for a pre-existing condition of the qualifying individual, continuation coverage will end as of the date the exclusion or limitation no longer applies;
- The date the qualifying individual becomes entitled to coverage under Medicare; and
- The first day of the month that begins more than 30 days after the qualifying individual who was entitled to a 29-month maximum continuation period is subject to a final determination under the Social Security Act that he or she is no longer disabled.

Note: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all health insurance carriers that offer coverage in the individual market accept any eligible individuals who apply for coverage without imposing a pre-existing condition exclusion. In order to be eligible to apply for such coverage from a carrier after ceasing participation in the Plan, you or your eligible dependents must elect continuation coverage under the Plan, continue through the maximum continuation coverage period (18, 29, or 36 months, as applicable), and then apply for coverage with the individual insurance carrier before a 63 day lapse in coverage. For more information about your right to such individual insurance coverage, contact an independent insurance agent or your state insurance commissioner.

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

Notice of Termination Before Maximum Period of COBRA Coverage Expires

If continuation coverage for a qualifying individual terminates before the expiration of the maximum period of continuation coverage, the Plan Administrator will provide notice to the individual of the reason that the continuation coverage terminated, and the date of termination. The notice will be provided as soon as practicable following the Plan Administrator's determination regarding termination of the continuation coverage.

The Plan intends to comply with all applicable law regarding continuation (COBRA) coverage. If for some reason the information presented in this Plan differs from actual COBRA requirements, the Plan reserves the right to administer COBRA in accordance with such actual COBRA requirements.

VI. SUMMARY OF PLAN BENEFITS

The Plan provides eligible employees and their eligible dependents with health insurance. These benefits are provided under the Group Insurance Contracts with the Insurance Carriers. A summary of the benefits provided under the Plan is in the documents issued by the Insurance Carriers.

The Plan, through the Group Insurance Contracts, provides benefits in accordance with the applicable requirements of federal laws, such as Employee Retirement Income Security Act (ERISA), Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability Accountability Act (HIPAA), Newborns' and Mothers' Health Protection Act (NMHPA), Mental Health Parity Act (MHPA), and the Women's Health and Cancer Rights Act (WHCRA).

VII. PLAN ADMINISTRATION

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

A. Administration

The plan is fully insured. Benefits are provided under the Group Insurance Contract entered into between the Employer and the Insurance Carrier. Claims for benefits are sent to the Insurance Carrier, and the Insurance Carrier, not the Employer, is responsible for paying them. The Insurance Carrier is also responsible for determining eligibility for and the amount of any benefits payable under the Plan and prescribing claims procedures and forms to be followed to receive Plan benefits.

The Insurance Carrier also has the discretionary authority to require participants to furnish it with such information as it determines is necessary for the proper administration of claims for Plan benefits.

B. Amendment or Termination of the Plan

As Plan Sponsor, the Employer has the right to amend or terminate the Plan at any time. You have no vested or permanent rights or benefits under the Plan. Plan benefits will typically change from year-to-year and you should examine the SPD provided to you each year to determine the benefits of the Plan.

C. No Contract of Employment

The Plan is not intended to, and does not, either directly or indirectly constitute any form of employment contract or other employment arrangement between you and Employer.

D. Other Materials

The Certificates of Coverage (including the Member Payment Summary, and the Provider & Facility Directory) issued by the insurance carriers are part of the Summary Plan Description. Please refer to these materials for other important provisions regarding your participation in the Plan.

E. Claims and Appeals

Fully Insured Benefits

The insurer that provides insured Benefits is responsible for paying claims and making benefits decisions for the fully insured Benefits under the plan. The claims procedures applicable to the insured Benefits are described in the applicable Benefit document.

VIII. HIPAA PRIVACY AND SECURITY

The Notice of Privacy Practices ("Notice") describes the legal obligations of the Plan and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). The Insurance Carriers hold the primary obligation of providing you with this Notice for their respective benefits.

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:

- your past, present, or future physical or mental health or condition;
- the provision of health care to you; or
- 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 the Plan Administrator.

Employer Responsibilities

The Plan Sponsor is 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 the Plan Sponsor's legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the privacy policy that is currently in effect.

The Plan Sponsor reserves the right to change the terms of this privacy policy and to make new provisions regarding your protected health information that it maintains, as allowed or required by law.

IX. ADDITIONAL RIGHTS

Your Rights Under The Employee Retirement Income Security Act (ERISA)

As a participant in the Plan (which is a type of employee welfare plan called a "group plan") you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all group plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another group plan. You should be provided a certificate of creditable coverage, free of charge, from a group plan or a health insurance issuer when you lose coverage under a group 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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the 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, Pension and Welfare Benefits 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 at 1.866.444.EBSA. You may also visit its website at www.dol.gov/ebsa.

Newborn's and Mother's Health Protection Act

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

Women's Health and Cancer Rights Act of 1998 (WHCRA)

As required by the WHCRA, group plans are required to provide benefits for mastectomy- related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). An employee may obtain, without charge, additional information from the Plan Administrator.

Genetic Information Nondiscrimination Act of 2008

Group plans are subject to the provision of GINA, which expands the genetic information nondiscrimination protections included in Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under GINA, premiums for a plan or a group of similarly situated individuals cannot be based on genetic information. GINA "generally prohibits plans and issuers 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."

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

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 on the notice in the link 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).

For more information on which states offer this coverage and how to contact them, please go to:
www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf