SUMMARY PLAN DESCRIPTION
OF THE UNALLOCATED MEDICAL REIMBURSEMENT PLAN

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ARTICLE I.
INTRODUCTION

Your Employer, (the "Employer"), is pleased to sponsor an employee benefit program known as the Unallocated Medical Reimbursement Plan (UMR) to be known as (the "Plan") for certain eligible employees. This summary plan description describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. It is only a summary of the key parts of the Plan, and a brief description of your rights as a participant. To make maximum use of this Plan, be sure to proceed through this booklet carefully, so that you can make informed decisions that are right for you. If there is a conflict between the underlying Plan and this summary plan description, the intention is for the Plan Document to govern.

If you have any unanswered questions after reading the summary, please contact either the Employer or the Claims Administrator.

ARTICLE II.
GENERAL INFORMATION ABOUT THE PLAN

2.1 What is the purpose of the Plan?

The purpose of the Plan is to provide certain Employees with an opportunity to receive reimbursement for eligible Health Care Expenses in accordance with the Adoption Agreement as provided in this Plan. It is the intention of the Employer that the benefits payable under this Plan be eligible for exclusion from the gross income of Participants as provided by Sections 105(b) and 106 of the Internal Revenue Code (the "Code").

2.2 When did the Plan take effect?

The Plan became effective as defined in the attached Adoption Agreement. It operates on a Plan Year described in the attached Adoption Agreement.

2.3 Who can participate in the Plan?

Each employee, who according to the attached Adoption Agreement fully meets all of the outlined criteria to participate in this Plan. These employees are called Eligible Employees. Those Eligible Employees who actually participate in the Plan are called "Participants."

"**Employee**" means a common-law employee of the Employer who is on the Employer's W-2 payroll, except that the term "Employee" does not include any common-law employee who is a leased employee (including but not limited to an individual defined in Code § 414(n)), or any common-law employee who is an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is on the Employer's W-2 payroll. The term "Employee" also does not include any individual who performs services for the Employer, but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement unless the collective bargaining agreement so provides. The term "Employee" includes "former employees" for the limited purpose of allowing continued eligibility for benefits hereunder If this entity is a S Corporation, add the following "The term "Employee" also does not include individuals deemed to be self employed by the Code, including individuals owning more than 2% of the Employer and their spouse, children, grandchildren, and parents."

2.4 How do I enroll?

Once you become eligible to participate, you will automatically be enrolled in the Plan and become a Participant. You may or may not be required to complete a special enrollment form to enroll in this Plan**.**

2.5 How long will I be able to participate in the Plan?

Reimbursements: Claim reimbursements on your behalf cease upon the earliest of the following: (1) the date of your death; (2) the date of your failure to meet the eligibility requirements described in Section 2.3, including upon termination of your employment; or (3) the date of termination of the Plan.

In addition, your participation in the Plan may be terminated for cause including, but not limited to, your failure to follow Plan rules or your failure to cooperate with the Claims Administrator or Plan Administrator.

Note: Termination of participation may entitle you to continuation coverage as described in Article IV. There is a special rule for retirees. If you retire from the Employer and you are eligible for and enroll in retiree coverage under the group medical coverage sponsored by the Employer, your participation will not cease based upon the termination of your employment. You will remain eligible to receive reimbursement for eligible claims until your participation is terminated for one of the other reasons (i.e., other than termination of employment) identified above.

2.6 How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to amend or terminate the program in whole or in part at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended or terminated accordingly. You will be informed if changes are made to the Plan.

2.7 How does reimbursement under this Plan affect my tax deductions?

You should realize that any medical expense for which you are reimbursed under this Plan cannot be claimed as a medical expense deduction on your income tax return. However, unless your health expenses exceed seven and one-half percent (7.5%) of your adjusted gross income, you are not permitted to use the deduction anyway.

ARTICLE III. Unallocated Medical Reimbursement

UNALLOCATED MEDICAL REIMBURSEMENT

3.1 What is an Unallocated Medical Reimbursement Plan?

An Unallocated Medical Reimbursement Plan is a self-funded medical plan as established in the Basic Plan Document and Adoption Agreement. The Plan is considered unallocated in that there is no specific account set up for a particular Participant, claims are paid out of the general assets of the Employer and the amount that any particular Participant may receive is wholly dependent upon the claims incurred and submitted for reimbursement. The Employer will pay claims eligible for reimbursement according to the Adoption Agreement. The **amount and types of claims that will be eligible for reimbursement through this Plan** will be communicated to you by the Employer prior to the beginning of each Plan Year and noted in the Summary Plan Description.

There is no trust. Benefits under the Plan are paid from the Employer's general assets.

3.2 What is an "eligible" Health Care Expense?

Only eligible Health Care Expenses may be reimbursed under this Plan**.** The definition of an eligible Health Care Expense is included in the attached Adoption Agreement. Furthermore, to be an eligible Health Care Expense, the expense: (1) must be "incurred" while you are a Participant; and (2) must be "incurred" for yourself, your eligible Spouse or your eligible Dependents. An expense is "**incurred**" when the service that gives rise to the expense has been provided, not when you are billed or when you pay for the expense.

"**Spouse**" means an individual who is legally married to you and who is treated as your Spouse under the Internal Revenue Code.

"**Dependent**" means a dependent for purposes of Section 105 of the Internal Revenue Code. Generally, "dependent" includes a qualifying child and certain other relatives. A qualifying child is a child who: (a) is your child (son, daughter, stepson, or stepdaughter), brother, sister, stepbrother, or stepsister, or a descendant of any such person; (b) has the same principal place of abode as you for at least one-half of the relevant year; (c) will not attain age 19 (or age 24 if a full time student) during the relevant year or is permanently and totally disabled; and (d) did not provide over half of his/her own support during the relevant year or as set forth in The Patient Protection and Affordability Care Act of 2010. If the definition of age attainment of a dependent or definition of a dependent on your group health policy differs from the above definition, the group health policy definition will supersede that of the above definition.

3.3 How do I receive my benefits under the Plan?

When you incur an expense that has been submitted to the group health plan first and is eligible for reimbursement, you must submit a claim to the Claims Administrator on a reimbursement form that will be supplied to you. The form will typically require:

(1) the amount, date and nature of the expense,
(2) the name of the person or entity to which the expense was paid,
(3) your statement that the expense has not been reimbursed or is not reimbursable through any other source, and
(4) such other information as the Claims Administrator may require.

You may also be required to submit copies of bills or receipts from the provider(s) to support your claim. Reimbursements are paid by separate check. In order to be eligible for payment, you must submit a claim within ninety (90) days from the end of the Plan Year in which the expense is incurred.

"**Claims Administrator**" is as outlined in the attached Adoption Agreement

3.4 What if my claim exceeds what is outlined in the Adoption Agreement?

The maximum reimbursement you may receive at any time is determined as outlined in the Adoption Agreement. If a claim exceeds the amount of the available reimbursement, only the portion eligible for

reimbursement at that time will be processed. Excess amounts can either be paid out of pocket or submitted to a Section 125 HCR account if applicable**.** The maximum reimbursement requirements apply to you, your Spouse, and your Dependents on an aggregate basis, not an individual basis.

3.5 Do I submit claims for reimbursement under my Employer's cafeteria plan first?

No. Claims for eligible Health Care Expenses (see Question 3.2) must first be submitted for reimbursement under this Plan.

3.6 What happens if my claim for benefits is denied?

In most cases, within thirty (30) days after a claim for benefits is filed, the claim will either be paid or the Claims Administrator will notify you of the claim denial. If the Claims Administrator denies the claim, you will be provided with the following information in writing:

(1) The specific reasons for the denial;

(2) The specific reference to the Plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary; and

(4) Appropriate information as to the steps to be taken if you wish to appeal the Claims Administrator's determination, including your right to submit written comments and have them considered, and your right to file suit under Employee Retirement Income Security Act of 1974 ("ERISA") with respect to any adverse determination after appeal of your claim.

Within one hundred eighty (180) days after you receive notice that your claim has been denied, you or your representative may file a written request with the Claims Administrator appealing the denial and requesting review of it. You or your representative are entitled to review the pertinent documents and may also submit issues and comments in writing to be considered as part of the review of it. An adverse benefit determination eligible for appeal includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based, among other things, on: a determination of an individual's eligibility for coverage; the imposition of a preexisting condition exclusion; or a denial of part of the claim due to the terms of a coverage documents regarding co-pays, deductibles, or other cost sharing requirements.

"**Authorized representative**" means a person entitled to act on your behalf and recognized by the Plan Administrator. In order to be recognized by the Plan Administrator, the person must have a completed "Authorized Representative Form" on file with the Claims Administrator.

The Plan Administrator will review and decide your appeal within a reasonable time not longer than sixty (60) days after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate. The Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. (The identity of a medical expert consulted in connection with your appeal will be provided.) Every notice of determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

All appeals receive a full and fair review. You will be provided, free of charge, with any "new or additional evidence considered, relied upon, or generated, in connection with the claim and you will be provided with a reasonable opportunity to respond to any such new or additional evidence. You may request that the appeal process be expedited if (a) the time frames under this process would seriously jeopardize your life, health, or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain which cannot be managed without ht requested services; or (b) your appeal involves nonauthroization of an admission or continuing inpatient Hospital Stay. When an appeal is expedited, the Plan Administrator will respond orally with a decision within 24 hours *beginning plan year after July 1, 2011.* External reviews are available in accordance with the laws of the state of which your employer is domiciled.

3.7 What if I am subject to a medical child support order?
Notwithstanding any provision of the Plan to the contrary, the Plan shall recognize **Qualified Medical Child Support Orders ("QMCSOs")**, effective on and after August 10, 1993. To be recognized, specific procedures must be followed. If you are involved in a divorce or child custody matter, you or your legal counsel should contact the Plan Administrator.

3.8 Will I have any administrative costs under the Plan?
No. The cost of administering the Plan is paid by the Employer from its general assets.

3.9 What happens to my UMR if my participation in the Plan terminates?
If your participation in the Plan terminates as described in Section 2.5 all access to your UMR will terminate.

ARTICLE IV.

CONTINUATION COVERAGE
A Participant, and any others who are covered through that Participant, **may** be entitled to elect to continue coverage under the Plan in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), or the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"), as described below.

4.1 What are my continuation rights under COBRA?
Most Employers are subject to COBRA regardless of their group size. COBRA requires most employers to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all of the premiums for the continuation coverage. This notice is intended to inform persons covered under the Plan, in summary fashion, of their rights and obligations under the continuation coverage provision of the law. It is intended that no greater rights be provided than those required by this law. It does not fully describe your continuation coverage rights. The Plan Administrator has developed additional policies regarding the provision of continuation coverage under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator. This notice covers only this Plan.

Each person covered under the Plan should read this notice carefully.

Qualifying Events: Upon the commencement of a "qualifying event" each person that loses coverage may have rights as a "qualified beneficiary."

Qualifying event: A qualifying event is the occurrence of an enumerated event (described below) that results in a loss of coverage under the terms of the group health plan.

Qualifying beneficiary: A qualified beneficiary is the employee, employee's spouse and/or employee's dependent children who on the day before the qualifying event was covered under this group health plan. A spouse whose coverage was reduced or terminated in anticipation of divorce is also a qualified beneficiary. In addition, a child born to or place for adoption with a qualified beneficiary **who was the employee** is a qualified beneficiary is if he or she was covered under this group health plan on the day before the qualifying event. Furthermore, an individual for whom the employee must provide coverage under the group health plan pursuant to a medical child support order is a qualified beneficiary.

Employee Loss: If covered by any of the group health plans described above, the employee has the right to elect continuation coverage if he or she loses coverage under such plan due to termination of employment (other than for gross misconduct) or a reduction in hours of employment.

Spouse's Loss. If covered by any of the group health plans described above, a spouse has the right to elect continuation coverage if he or she loses coverage under such plan due to any of the following: the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment; the employee's death; or divorce or legal separation from the employee.

Note: If an employee eliminates coverage for his or her spouse from coverage in anticipation of a divorce of legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier.

Dependent Child's Loss. If covered by this group health plan described above, a

dependent child has the right to elect continuation coverage if he or she loses coverage under such plan due to any of the following:

- the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment;
- the employee's death;
- divorce or legal separation of the employee and the child's other parent; or
- the child ceasing to be a "dependent child" under the terms of the plan.

Employer's Bankruptcy. Rights similar to those described above may apply to retirees (and the spouses and dependents of those retirees), if the employer commences a Chapter 11 bankruptcy proceeding.

Responsibility to Notify. In certain circumstances, you are required to provide notification to the Plan Administrator in order to protect your rights under COBRA.

Notice of Qualifying Event. Under the law, the employee or a family member (or a representative acting on behalf of the employee or a family member) has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the plan within sixty (60) days of the latest of: (1) the date of the qualifying event; (2) the date coverage would be lost because of the qualifying event; or (3) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notification must be provided in writing and be mailed to the Plan Administrator at the address identified below. Oral notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notification must be postmarked no later than the last of the sixty (60) day notice period described above. The notification must:

(1) state the name of the Plan;
(2) state the name and address of the employee or former employee who is or was covered under the Plan;
(3) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the qualifying event;
(4) include a detailed description of the event;
(5) identify the effective date of the event; and
(6) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no continuation coverage will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no continuation coverage will be provided.

You must, if the Plan Administrator requests it, provide documentation of the date of the qualifying event that is satisfactory to the Plan Administrator, so that the Plan Administrator can determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA. If you are unable to provide satisfactory evidence within thirty (30) days after a written or oral request from the Plan Administrator, the coverage may be terminated (retroactively if necessary) as of the date that COBRA coverage would have started. The Plan will require repayment to the Plan of all benefits paid after the termination date.

Notice of Second Qualifying Event: In addition, the employee or a family member (or a representative acting on behalf of the employee or family member) must notify the Plan Administrator of the death of the employee, divorce or separation from the employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan, if that event occurs within the eighteen (18) month continuation period (or an extension of that period for disability or for pre-termination Medicare entitlement). The notification must be provided within sixty (60) days after such a second qualifying event occurs in order to be entitled to an extension of the continuation period. The notification must be provided in writing and be mailed to the Plan Administrator at the address identified below. Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notification must be postmarked no later than the last day of the sixty (60) day notice period described above.

The notification must:

(1) state the name of the Plan;
(2) state the name and address of the employee or former employee who is or was covered

under the Plan;
(3) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;
(4) identify the nature and date of the initial qualifying event the qualified beneficiaries to COBRA coverage;
(5) include a detailed description of the event;
(6) identify the effective date of the event; and
(7) be accompanied by any documentation providing proof of the event (i.e., the divorce decree). If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan Administrator is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.
You must, if the Plan Administrator requests it, provide documentation of the date of the second qualifying event that is satisfactory to the Plan Administrator, so that the Plan Administrator can determine if you gave timely notice of the second qualifying event. If you are unable to provide satisfactory evidence within thirty (30) days after a written or oral request from the Plan Administrator, the coverage may be terminated (retroactively if necessary) as of the date that the extension of COBRA coverage would have started. The Plan will require repayment to the Plan of all benefits paid after the termination date.
Notice of Disability: Also, an employee or a family member (or a representative acting on behalf of the employee or a family member) must notify the Plan Administrator when a qualified beneficiary has been determined to be disabled under the Social Security Act within sixty (60) days of the latest of: (1) the date of the disability determination; (2) the date of the qualifying event; (3) the date coverage would be lost because of the qualifying event; or (4) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. (Notwithstanding the foregoing, the notice must be provided before the end of the first eighteen (18) months of continuation coverage.) The notification must be provided in writing and be mailed to the Plan Administrator at the address identified below.

Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notification must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:
(1) state the name of the Plan;
(2) state the name and address of the employee or former employee who is or was covered under the Plan;
(3) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;
(4) identify the nature and date of the initial qualifying event the qualified beneficiaries to COBRA coverage;
(5) state the name of the disabled qualified beneficiary;
(6) identify the date upon which the disabled qualified beneficiary became disabled;
(7) identify the date upon which the Social Security Administration made its determination of disability; and
(8) include a copy of the determination of the Social Security Administration.
If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan Administrator is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided with thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.
If such person has been determined under the Social Security Act to no longer be disabled, the person must notify the Plan Administrator of that determination within thirty (30) days of the later of: (1) the date of such determination; or (2) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notice must be in writing and be mailed to the Plan Administrator at the address identified below. Regardless of when the notification is provided, continuation coverage will terminate retroactively on the first day of the month that begins thirty

(30) days after the date of the determination, or the end of the initial coverage period, if later. If you do not provide the notification within the required time, the Plan reserves the right to seek reimbursement of any benefits provided by the Plan between the date coverage terminates and the date the notification is provided.

Failure to provide timely notification of a qualifying event ends the right to COBRA continuation coverage.

Election Rights: When a qualifying event occurs, or when the Plan Administrator is notified that a qualifying event has occurred in the case of those events in which the employee has an obligation to provide notice, the Plan Administrator must notify the qualified beneficiaries of the right to elect continuation coverage. Because the Employer and the Plan Administrator are the same entity, the Plan Administrator has forty-four (44) days to provide the option to elect COBRA coverage. Under the law, qualified beneficiaries have at least sixty (60) days to elect continuation coverage measured from the later of (1) the date coverage would be lost because of a qualified event, or (2) the date a notice of election rights is provided. An election is considered "made" on the date sent. If continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If continuation coverage is not elected within this period, coverage under the Plan ends.

Each qualified beneficiary has an independent right to elect continuation coverage. Employees and spouses (if the spouse is a qualified beneficiary) may elect continuation coverage on behalf of all qualified beneficiaries and parents may elect continuation coverage on behalf of their children. Furthermore, other third persons can elect continuation coverage on behalf of a qualified beneficiary.

Note: Qualified beneficiaries who are entitled to elect COBRA may do so even if they are covered by Medicare effective on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if he or she first becomes covered by Medicare effective after the date on which COBRA is elected.

Duration: The law requires that qualified beneficiaries generally be allowed to maintain continuation coverage as follows:

Eighteen (18) Months: If the qualifying event is the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment, the continuation period is eighteen (18) months measured from the date of the qualifying event.

Disability Extension: For qualified beneficiaries receiving continuation coverage because of the employee's termination or reduction in hours, the continuation period may be extended eleven (11) months, for a total maximum of twenty-nine (29) months where a qualified beneficiary receives a determination under the Social Security Act that at the time of the employee's termination of employment or reduction of hours, or within sixty (60) days of the start of the eighteen (18) month continuation period, the qualified beneficiary was disabled. The extension is available to all qualified beneficiaries in the family group.

Pre-Qualifying Event Medicare Extension: The eighteen (18) month continuation period may be extended if the employee became entitled to (actually covered under) Medicare prior to the employee's termination of employment (other than for gross misconduct) or a reduction in hours. Qualified beneficiaries other than the employee are entitled to the greater of (1) eighteen (18) months measured from the qualifying event, or (2) thirty-six (36) months measured from the date of the employee's Medicare entitlement.

Thirty-Six (36) Months: For qualifying events other than termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period is thirty-six (36) months measured from the date of the qualifying event.

Second Qualifying Events: If during the initial eighteen (18) month continuation period (or during an extension of that period for disability or for pre-termination Medicare entitlement) a second qualifying event occurs (e.g., divorce or legal separation, death of employee, loss of dependent status) that would have caused the qualified beneficiary to lose coverage under the Plan had the first qualifying event not occurred the continuation period for the particular qualified beneficiaries affected by the second qualifying event may be extended to thirty-six (36) months.

Under no circumstances may the total continuation period be greater than thirty-six (36) months from the date of the original qualifying event that triggered the continuation coverage.

Type of Coverage: Initially, the coverage will be the same coverage as immediately preceding the qualifying event. Thereafter, coverage must be identical to the coverage provided to similarly situated employees or family members that have not experienced a qualifying event. In addition, special enrollment

rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") will apply to those who have elected COBRA.

Cost: A person electing continuation coverage may have to pay all or part of the cost of continuation coverage. You will receive additional information regarding the cost requirements following the occurrence of a qualifying event. The amount charged cannot exceed 102% of the cost to the Plan of providing the coverage. The amount may be increased to 150% for the months after the eighteenth (18th) month of continuation coverage when the additional months are due to a disability under the Social Security Act. Payment is generally due monthly. Payment is considered "made" on the date sent.

Premature Ending: The law provides that continuation coverage shall automatically end for any of the following reasons:

• the Employer no longer provides group health coverage to any of its employees;

• the premium for continuation coverage is not paid on time (including any applicable grace period);

• after electing COBRA, the qualified beneficiary becomes covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any applicable pre-existing condition that you have;

Note: Under HIPAA, an exclusion or limitation of the other group health plan might not apply at all, depending on the length of the qualified beneficiary's creditable coverage prior to enrolling in the other group health plan. If the other plan has applicable exclusions or limitations, then COBRA coverage terminates after the exclusion or limitation no longer applies (for example, after a twelve (12) month pre-existing condition waiting period expires).

• after electing COBRA coverage, the qualified beneficiary becomes entitled to (actually covered under) Medicare;

Notice Obligation: The employee or a family member must notify the Plan Administrator immediately if any qualified beneficiary actually becomes covered by another group health plan or Medicare. Regardless of when such notification is provided, coverage will terminate retroactively to the date of the coverage under the other group health plan or Medicare. If, for whatever reason, a qualified beneficiary receives any medical benefits under the Plan after coverage is to cease under these rules, the Plan reserves the right to seek reimbursement from the qualified beneficiary.

• with respect to disability extension coverage, a final determination that the qualified beneficiary is no longer disabled; or

Note: This cuts short the coverage for all qualified beneficiaries with extended coverage.

• termination for cause under the generally applicable terms of the group health plan (e.g., submission of fraudulent benefit claims).

Address Changes: Important information is distributed by mail. In order to protect your family's rights if a qualified beneficiary's address changes, the qualified beneficiary or someone on its behalf should notify the Plan Administrator immediately. **More Information:** All questions, notices, and other communications regarding COBRA and the Plan should be directed to: The Plan Administrator as outlined in the attached Adoption Agreement.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

More Information: Your Employer has contracted with a third party to provide assistance with administering its COBRA obligations. All questions, notices, and other communications regarding COBRA and the Plan should be directed to the COBRA Administrator as outlined on the Adoption Agreement. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans,

contact the nearest Regional District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

4.2 What are my continuation rights under USERRA?

USERRA requires all employers to offer employees and their families (spouse and/or dependent

children) the opportunity to pay for a temporary extension of health coverage (called "U-continuation coverage") at group rates where health coverage under employer-sponsored group health plan(s) would otherwise end because of the employee's service in the uniformed services.

This notice is intended to inform persons covered under a group health plan, in summary fashion, of their rights and obligations under the continuation coverage provision of USERRA. It is intended that no greater rights be provided than those required by this law. It does not fully describe your U-continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact the USERRA Administrator.

This notice covers this Plan only.

Each person covered under the Plan(s) should read this notice carefully.

Service Leave Event. If covered by any of the group health plans described above, the employee has the right to elect U-continuation coverage for him/herself and his/her dependents if they lose coverage under such plan due to an absence from employment for service in the uniformed services (a "service leave").

Service in the Uniformed Services. Service in the uniformed services generally means the voluntary or involuntary performance of duties in the uniformed services. The uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

Election Rights. You have sixty (60) days to elect U-continuation coverage, measured from the date your absence from employment for the purpose of performing service begins. An election is considered "made" on the date sent. If U-continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If U-continuation coverage is not elected within this period, coverage under the Plan ends. However, if the no election is made in a situation in which you are not required (in accordance with USERRA) to provide advance notice of your service (e.g., because such notice was impossible, unreasonable, or precluded by service necessity), your coverage will be reinstated on a retroactive basis upon your election to continue coverage (regardless of when it is received) and payment of all unpaid amounts due.

Note: Your dependents with coverage under the Plan(s) do not have an independent right to elect U-continuation coverage. Their coverage may be continued only if you elect U-continuation coverage.

Duration. The law requires that you generally be allowed to maintain U-continuation coverage for a twenty-four (24) month period beginning on the date of your absence from employment for the purpose of performing service begins.

Type of Coverage. Initially, the coverage will be the same coverage as immediately preceding your service leave. Thereafter, coverage will be the same as the coverage provided to similarly situated employees or family members that are not on service leave.

Cost. A person electing U-continuation coverage may have to pay all or part of the cost of U-continuation coverage. If you perform service in the uniformed services for fewer than thirty-one (31) days, you will pay the same amount for the coverage that you normally pay. If your service exceeds thirty (30) days, the amount charged cannot exceed 102% of the cost to the plan of providing the coverage.

Payment is generally due monthly on the first day of the month. Payment is considered "made" on the date sent. You will be given a grace period of within which to make the payment.

The length of the grace period will be thirty days (30).

Termination of the Continuing Coverage. The U-continuation coverage may be terminated for any of the following reasons:

- the Employer no longer provides group health coverage to any of its employees;
- the premium for U-continuation coverage is not paid on time (including the grace period);
- your failure to return from service or apply for a position of employment as required under USERRA; or
- termination for cause under the generally applicable terms of the group health plan (e.g., submission of fraudulent benefit claims).

ARTICLE V.

FAMILY AND MEDICAL LEAVE ACT OF 1993

5.1 Family and Medical Leave Act of 1993 ("FMLA")

The Family and Medical Leave Act of 1993 ("FMLA") imposes certain obligations on employers with fifty (50) or more employees. This Plan shall be administered in a manner consistent with the FMLA and your Employer's FMLA Policy required there under.

INFORMATION ON COVERAGE

There is no longer any lifetime limit on the dollar value of essential health benefits under this Plan. There is no annual dollar limit imposed on essential health benefits under the Plan. For more information contact the Plan Administrator.

The Plan does not impose any preexisting condition exclusion against a child under the age of 19. Beginning 2014 the Plan does not impose any preexisting condition exclusion against any participant, regardless of age.

Once an individual has become a covered participant under the Plan, the Plan will not rescind coverage of the individual unless he or she committed fraud or made an intentional misrepresentation of material fact. A rescission of coverage is the cancellation or discontinuation of coverage, other than for failure to pay premiums, which has a retroactive effect. The Plan or issuer will provide notice of the rescission 30 days in advance; the notice will inform the affected group or participant of the opportunity to appeal the determination to rescind.

Claims Appeals

Participants have a right to appeal claim payment determinations and denied claims. If a Participant disagrees with any claim payment determination or believes that a claim was denied in error, the Participant can appeal. When filing an Appeal, the Participant or the Participant's representative should explain why the Participant feels the original decision should be overturned and submit any other information the Participant thinks is relevant. The appeal should be made as soon as possible after you receive the original decision, but no later than six months after the Pre-Authorization request was denied or six months after the claim for benefits was denied, whichever comes first.

Each appeal provides full and fair review of an adverse determination in compliance with the Employee Retirement Income Security Act of 1974 ("ERISA") and the regulations issued there under. The Participant will be provided free of charge with a complete description of the Plan's review procedures and the applicable time limits by contacting the Plan Administrator. Briefly, claimant may file an appeal within six months after the Pre-Authorization request was denied or six months after the claim for benefits was denied, whichever comes first.

If participant provides the Plan with all information needed to address the appeal, the Plan will respond to the appeal not later than 30 days after receipt of the request for the appeal. Participant is entitled to receive, free of charge upon request, reasonable access to, and copies of, all documents, records and other information relevant to a claim for benefits. If Participant receives an adverse benefit determination following the final appeal, Participant has the right to bring a civil action under section 502(a) of ERISA.

The Appeal request may be initiated orally, electronically, or by mail, by calling, faxing or writing to **Plan Administrator**:

Qualified Medical Support Orders (QMSO)

Generally your Plan benefits may not be assigned or alienated. However, an exception applies in the case of "qualified medical child support order." Basically, a qualified medical child support order is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either (1) creates or extends the rights of an "alternate recipient" to participate in a group health plan, including this Plan, or (2) enforces certain laws relating to medical child support. An "alternate recipient" is any child or a Participant who is recognized by a medical child support order as having a right to enrollment under the Participant's group health plan.

A medical support order must satisfy certain specific conditions to be qualified. You will be notified by the Plan Administrator if it received a medical child support order that applies to you and the Plan's procedures for determining whether the medical child support order is qualified.

Uniformed Service under USERRA

Continued Participation in the Plan may be permitted under certain conditions when you are serving in the United States military after having been a Participant in this Plan. See your Plan Administrator for the provisions of this continuation.

ARTICLE VI.

ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of l974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

1) Examine, without charge, at the Benefits Administrator's office, as part of the Plan Administrator's (plan sponsor, i.e., your employer) office, and at other specified locations such as work sites, all documents governing the Plan, including insurance contracts, and copies of all documents filed by the Plan, such as detailed annual reports and Plan descriptions, with the United States Department of Labor applicable only if member contribution applies;

2) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator (plan sponsor, i.e., your employer). The Plan Administrator may make a reasonable charge for these copies.

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. Review reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect 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 the 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 you and other members, ERISA imposes duties upon the people who are responsible for the operation of your member benefit Plan. The people who operate your Plan are called "fiduciaries" of the Plan. They must handle your Plan prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA.

Enforce Your Rights

If your claim for a health or welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Benefits Administrator and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the

Plan Administrator (plan sponsor, i.e., your employer) 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 your claim benefit is denied or ignored, in whole or in part, you may file suit in a court of competent jurisdiction. If Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator (plan sponsor, i.e., your employer). If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area 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, 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.

Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and your employer. The Employer's rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

Legal Control

The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan. This is a Summary Plan Description only. (See statement of ERISA rights.) If there is a discrepancy between the description of the Plan as contained in this material and the official Plan Document, the language of the Plan Document will apply.

NOTICE OF PRIVACY PRACTICES

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

This notice of Privacy Practices describes how protected health information may be used or disclosed by your Group Health Plan to carry out payment, Health care operations and for other purposes that are permitted or required by law. This Notice also sets out legal obligations concerning your protected health information and describes your rights to access and control your protected health information.

Protected health information (or "PHI") is individually identifiable health information including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present or future payment for the provision of health care to you.

This Notice of Privacy Practices has been drafted to be consistent with what is known as the "HIPAA Privacy Rule" and any of the terms not described in this Notice should have the same meaning as they have in the HIPAA privacy Rule.

If you have any question or want additional information about the Notice or the policies and procedures as described in the Notice, please contact us at the number listed in the summary page of this Notice

OUR RESPONSIBILITES

We are required by law to maintain the privacy of your protected health information. We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to protected health information and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all protected health information that we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for the contract holder for your member contract.

PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following is a description of how we are most likely to use and/or disclose your protected health information.

Payment and Health Care Operations

We have the right to use and disclose your protected health information for all activities that are included within the definition of "payment" and "health care operations" as set out in 45 CFR Section 164.501 (this provisions a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 CFR Section 164.501 for a complete list.

Payment

We will use and disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your protected health information when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that your received was eligible for payment under Section 125.

Health Care Operations

We will use or disclose your protected health information to support our business functions. These functions include, but are not limited to: quality assessment and improvement, business planning and business development. For example, we may use or disclose your protected health information: (i) to respond to a customer service inquiry from you; or (ii) in connection with fraud and abuse detection and compliance programs.

Plan Sponsor

We may disclose your protected health information to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

Potential Impact of State Law

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individual greater privacy protections. As a result to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependence, genetic testing, reproductive rights, etc.

Other Possible Uses and Disclosures of Protected Health Information

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your protected health information.

Required by Law

We may use or disclose your protected health information to the extent that federal law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the Privacy Rule. For example,

we may disclose your protected health information when required by national security laws or public health disclosure laws.

Public Health Activities

We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We may also disclose protected health information, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

Health Oversight Activities

We may use or disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits, investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Abuse or Neglect

We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your information if we believe that you have been a victim of abuse, neglect, or domestic violence.

Legal Proceedings

We may disclose your protected health information: (i) in the course of any judicial or administrative proceeding; (ii) in response to and order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, of other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

Law Enforcement

Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (i) it is required by law or some other legal process; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on our premises.

To Prevent a Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend and individual.

Workers' Compensation

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Others Involved in Your Health Care

Using our best judgment, we may make your protected health information known to a family member, other relative, close personal friend or other personal representative that you identity. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

If you are not present or able to agree to these disclosures of your protected health information, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

REQUIRED DISCLOSURES OF YOUR PROTECED HEALTH INFORMATION

The following is a description of disclosures that we are required by law to make.

Disclosures to the Secretary of the U.S. Department of Health and Human Services.

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

Disclosures to You

We are required to disclose to you most of your protected health information in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your protected health information that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

We will disclose your protected health information to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose protected health information to such a person, you must submit a written notice of his /her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Other uses and Disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

YOUR RIGHTS

The following is a description of your rights with respect to your protected health information.

Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for payment or health care operations.

We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

You may request a restriction by calling us at the number listed in the summary page of this Notice. It is important that you direct your request for restriction to the noted address so that we can begin to process your request. Requests sent to persons or offices other than the number/ address indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (i) the information whose disclosure you want to limit; and (ii) how you want to limit our use and/or disclosure of the information.

Right to Request Confidential Communications

If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

You may request a restriction by calling/writing us at the number listed in the summary page of this Notice. It is important that you direct your request for restriction to the noted address so that we can begin to process your request. Requests sent to persons or offices other than the number/ address indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (i) the information whose disclosure you want to limit; and (ii) how you want to limit our use and/or disclosure of the information.

We will accommodate a request for confidential communications that is reasonable, and that states that the disclosure of all or part of your protected health information could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (e.g., an EOB). Unless you have made other payment arrangements, the EOB (in which your protected health information might be included) will be released to the plan participant.

If you terminate your request for confidential communications, the restriction will be removed for *all* your protected health information that we hold including protected health information that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your protected health information will endanger you.

Right to Inspect and Copy

You have the right to inspect and copy your protected health information that is contained in a "designated record set". Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your protected health information that is contained in a designated record set, you must submit your request by calling us at the number listed in the summary page of this Notice. It is important that you call this number to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the one indicated might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy you protected health information in limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact us at the number provided in this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

Right to Amend

If you believe that your protected health information is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by calling or writing your employer as noted on the first page of this Summary Plan Description. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for restriction to

the noted address so that we can begin to process your request. Requests sent to persons or offices other than the number/ address indicated might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

Right of an Accounting

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of protected health information will be for purposes of payment or health care operations and therefore will not by subject to your right to and accounting. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to which we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to your employer. It is important that you direct your request for restriction to the address on the first page of this Summary Plan Description so that we can begin to process your request. Requests sent to persons or offices other than the number/ address indicated might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically.